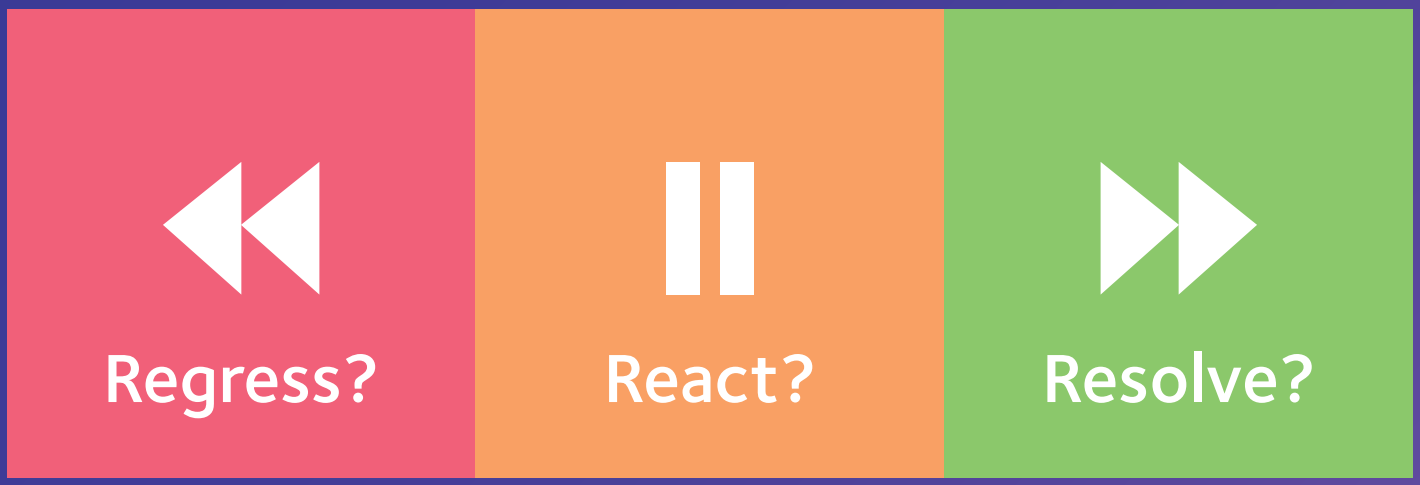

An evaluation of **mental health service provision** in Northern Ireland

Report prepared for Action Mental Health
by Queen's University Belfast

5 October 2015

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Regress? React? Resolve?

An Evaluation of
Mental Health Service Provision in Northern Ireland

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Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015)

5th October 2015

An Evaluation of Mental Health Service Provision in Northern Ireland

"Current mental health services in Northern Ireland are stretched far too thinly for them to be able to provide the level of care that is required" (service user).

"They need to see us as human beings first...not a label" (service user).

"Worst-case scenario is that we go backwards instead of forwards – if mental health is forced to make more stringent savings then I cannot see how that could be done without significant reduction to existing service provision" (mental health commissioner).

Dr George Wilson

Principal Investigator and Lead Author

The Evaluation Team – Queen's University Belfast

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Foreword

In recent years there has been increasing recognition of mental ill health as a major public health issue. Mental health is now regarded as one of the four most significant causes of ill health and disability in Northern Ireland along with cardiovascular disease, respiratory disease, and cancer.[1] It is estimated that one in five people in Northern Ireland have a mental health problem at any one time.[2] Northern Ireland has been noted to have higher levels of poor mental health than anywhere else in the United Kingdom or Ireland; for example, the prevalence of mental health problems is 25% higher in Northern Ireland compared with England.[3] This statistic has been attributed, in part, to higher levels of unemployment and social deprivation and the legacy of the conflict in Northern Ireland. The current economic recession has also impacted significantly on the mental health of the population of Northern Ireland creating an additional source of emotional distress for individuals and families.

The 'Bamford Review' aimed to address Northern Ireland's wide range of mental health needs and for many signalled a new era for the provision of services. However, since its publication in 2007, there has been very limited research on the impact of policy, the costs involved, and service users' experiences of services. Also, there has been little study of mental health professionals' perspectives on the effectiveness of the services they provide. Action Mental Health was delighted to commission an Evaluation Team from Queen's University Belfast, led by Dr George Wilson, to conduct this study, which was designed to fill gaps in our knowledge and illuminate the challenges and opportunities for developing services. We hope that this report will make a useful contribution to the future development of mental health services in Northern Ireland.

David Babington, Chief Executive Officer (CEO), Action Mental Health

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[1]Department of Health, Social Services and Public Safety (2011) *Service Framework for Mental Health and Wellbeing,* Belfast: Department of Health, Social Services and Public Safety.

[2]Chief Medical Officer (2010) *Your Health Matters. The Annual Report of the Chief Medical Officer for Northern Ireland 2010,* Belfast: Department of Health, Social Services and Public Safety.

[3]Northern Ireland Association for Mental Health and the Sainsbury Centre for Mental Health (2004) *Counting the Cost. The Economic and Social Costs of Mental Health Problems in Northern Ireland,* Belfast: Northern Ireland Association for Mental Health and the Sainsbury Centre for Mental Health.

Contents

Executive Summary and Recommendations

Action Mental Health commissioned this study to explore the effectiveness of current mental health provision in Northern Ireland and to identify both the challenges and opportunities for developing services. An Evaluation Team from Queen's University Belfast, led by Dr George Wilson, surveyed the opinions of a wide range of staff working with people living with mental ill health in both the statutory and voluntary sectors. From the outset the study prioritised the need for service user and carer input - their voice was vital in assessing the effectiveness of services throughout the region. The study reviewed current mental health policy, funding and recent research literature, and explored the strengths, limitations, inconsistencies, and gaps in services across Northern Ireland. The project focused primarily on adult mental health services. Although the study did not aim to provide a comprehensive evaluation of children's mental health or specific issues, such as suicide, reference is made to these and other aspects of mental health provision in the findings when they have been raised by respondents during interviews.

The past decade has witnessed a period of major change in mental health in Northern Ireland and the process of modernization is set to continue with the planned introduction of new mental health capacity legislation. In reviewing the current state of mental health provision, this report aims to present a realistic picture of how people with mental illness in Northern Ireland are supported, which can be used as a resource to help inform the planning of future services and funding. Whilst the study recognises that considerable progress has been made in realising the 'Bamford Vision' for improving mental health provision, the findings also highlight significant limitations in current services. The recommendations arising from the study are designed to build on the strengths of current provision and address the gaps and limitations that were identified by the study. The most notable factors in these recommendations focus on the need to improve funding, address problems with fragmentation and gaps in service provision, and provide a new vision and leadership in mental health. The findings indicate that mental health services in Northern Ireland are at a major crossroads and there is a real danger that the gains made in recent years may be reversed by continuing financial restraint. The

recommendations, which are based on the actual experiences of staff working in these services and the people availing of such services, indicate the direction in which services should continue to be developed that will promote better mental health for the population of Northern Ireland. To meet the challenges that lie ahead and secure effective mental health care, the recommendations clearly indicate that it is essential to consider all aspects of provision, including hospital and primary care, care in community settings, public health education, and the development of more specialist services.

Recommendations

The following 10 recommendations have been informed by the findings from the different components of the study, including key messages from the literature review, analysis of mental health policies and costs, together with the results obtained from focus group meetings and individual interviews with service users, carers, mental health professionals, and commissioning staff. Each recommendation is supported by a brief summary of evidence based on the analysis of key themes emerging from the findings.

Recommendation 1

The Northern Ireland Executive should ensure that sufficient funding is made available for mental health in Northern Ireland to achieve the service improvements envisaged by the Bamford Review which have not yet been realised. It is also recommended that mental health should be ring-fenced from any budget cuts as a key means of delivering on the goals of the Review in the current financial climate.

Evidence: Whilst some progress has been made in developing community care provision, the evidence from all stakeholders who participated in this research was unanimous that mental health services had not fully delivered on the goals and objectives for improvement envisaged by the Bamford Review. There are concerns that the Bamford Action Plan has finished with no clear indication as to whether the oversight arrangements to drive change will remain in place. It's clear the under-financing of mental health services in Northern Ireland is a systemic and long-term

issue that is set to exacerbate in coming years. Over the period 2008-2014 actual spend on mental health by Trusts has been around 25% less than that proposed—whilst this demonstrates an attempt at redressing underfunding, it also demonstrates that the attempt failed.

A variety of stakeholders highlighted additional mental health needs in Northern Ireland stemming from the legacy of the Troubles and the region's high levels of social deprivation, poverty and unemployment. Feedback from stakeholders indicated that year on year efficiency savings had impacted negatively on the development of services, particularly in rural areas. Without the injection of additional funding it was felt the Bamford Vision for service improvement would not be achieved in full and the imposition of further efficiency savings would lead to reversals in developments that have already taken place. There is a need for greater clarity around the levels of mental health need in Northern Ireland, what levels and kind of expenditure would meet that need, and what the overall picture of expenditure on mental health services actually is.

Recommendation 2

The DHSSPS, in conjunction with the Health Social Care (HSC) Board and Trusts, should establish a regional working group to examine the extent and impact of mental health service fragmentation, including variations in access to mental health provision between urban and rural areas of Northern Ireland. The group should aim to identify how to develop greater integration and continuity between different services and specialisms and how to achieve better inclusion and communication with service users and carers.

Evidence: Feedback from a range of stakeholder groups indicated that increased fragmentation in mental health services had created serious obstacles for service users and carers being able to access the support they needed. It was felt that restrictive eligibility criteria coupled with poor communication with service users and carers had led in some areas to breakdowns in continuity and a lack of seamlessness in service delivery. The evidence indicated that service continuity and communication with service users and carers were particularly problematic during transitions between **c**hild and **a**dolescent **m**ental **h**ealth **s**ervices (CAMHS) and adult

mental health services. Serious concerns were expressed about the adequacy and appropriateness of existing adult service provision for meeting the needs of young people making these transitions and it was felt that more priority needed to be given to develop specialist services in this area. It was also felt that the provision of mental health services across Northern Ireland was uneven with people living in large rural catchment areas having significantly less access to services than people living in urban areas.

Recommendation 3

The results from this study support the establishment of an independent Mental Health Champion for Northern Ireland whose role would be to defend the rights and interests of people with mental health problems. The Mental Health Champion would be an authoritative and independent advocate and play a key role in ensuring that mental health services continue to be developed in a way that effectively meets the needs of service users and carers.

Evidence: There was a general consensus among stakeholders, including commissioners, that the Bamford Review had provided the impetus for achieving significant improvements in community mental health services and reducing dependence on inpatient hospital treatment. However, it was felt that the drive and vision that Bamford had provided had gradually diminished in recent years, and there was a serious risk that the advances gained would stall or be reversed against a background of continuing efficiency savings and financial restraint. Establishing the post of Mental Health Champion would fill the post-Bamford vacuum and create a focal point for renewing the vision, providing fresh momentum for change, and realising the improvements still needed to modernise mental health services in Northern Ireland in the 21st century.

Recommendation 4

It is vital that mental health professionals recognise the central role that carers play in supporting the (cared for) family member and, in lieu of this significant contribution, make continuing efforts to include them as partners in assessment, planning, decision-making, and reviewing processes.

Evidence: Carers frequently highlighted their experience of poor communication with professionals. Carers also expressed frustration that their contribution was not sufficiently acknowledged or valued. Taking time to listen, to show empathy, to essentially recognise the carers' role and the fact they often lived with the family member on a continuing basis, all these person-centred qualities, when they occurred, made a major difference to the carers' lives. Carers felt that professionals needed to be more responsive and better at providing timely support to address their needs. Of fundamental importance was hearing the carer's perspective and including them to a much greater extent in the care and treatment process. In essence, the quality of the carer's experience of the mental health system depended on the effectiveness of the 'triangle of care': the relationships between patient, carer and professional working according to sound communication, involvement, parity of esteem, and respect for rights.

Recommendation 5

Commissioners of mental health services and providers in statutory and voluntary sector organisations should continue to work towards promoting a recovery ethos and further developing service user and carer involvement in the planning and delivery of provision. Funding for the ImROC (implementing recovery through organisational change) process should be provided on a more permanent basis in order to sustain developments in this area.

Evidence: Mental health professionals and commissioners acknowledged that significant progress has been made in developing a recovery approach. Whilst the ImROC process and the establishment of Recovery Colleges were viewed as evidence of positive change in both statutory and voluntary sector organisations, respondents expressed the view that further developmental work was required to

ensure a recovery ethos was more firmly embedded in working practices with service users and carers. It was also emphasized that developments, such as ImROC, required more permanent funding if they were to be sustained. The findings provided evidence that a medical model approach still dominated mental health care in certain areas in Northern Ireland. Also, the results indicated there were competing perspectives among stakeholders as to what constituted a 'recovery approach'. Involving service users and carers more fully in service development and delivery at all levels was felt to be an essential prerequisite for promoting a recovery approach and changing cultures of mental health practice.

Recommendation 6

Commissioners of mental health services and professional staff in all sectors should continue to strive to promote a person-centred and relationship-based approach to service delivery.

Evidence: A primary message from service users and carers was the need to ensure a person-centred and relationship-based approach to service delivery. Both groups were very vocal in their views about how the mental health system ought to change – based on their own experience. Service users and carers expressed concern about what they perceived to be in some areas as a continued over-reliance on medication and a medical model approach. Rather than being treated 'like a number' or an object to be dealt with, there was a clear desire to be viewed, first and foremost, by professionals as a person with a unique background and needs. Both groups strongly expressed the need to be listened to, have their story heard, their rights acknowledged, and for professionals to treat them with respect. Qualities within professionals, such as empathy and care, together with ability to establish effective working relationships with service users and carers were viewed as being pivotal to satisfaction with service delivery.

Recommendation 7

All agencies involved in commissioning and providing mental health services should continue to prioritise efforts to reduce the stigma associated with mental ill health as a key objective. Also, there should be a renewed emphasis on promoting positive mental health as a key component of the public health agenda. Commissioners of services should invest additional resources in developing mental health education in schools and encouraging positive attitudes towards mental health in children and young people.

Evidence: The majority of stakeholders identified the need to reduce stigma high among the key priorities for improving mental health provision. It was acknowledged that although some improvement had taken place, a pervasive stigma was still attached to mental ill health and services were still considered something to be hidden from 'normal' view. Further work was required to combat societal stigma and alleviate the social isolation and discrimination experienced by service users and carers. It was suggested that greater financial investment was needed to 'normalise' mental health services and ensure they were accorded the same priority as physical health services. Raising public awareness and improving understanding of mental illness were considered essential for ensuring individuals and families received the care and treatment they needed. In this context, it was acknowledged that mental health promotion should be further developed in order to address more effectively the stigma surrounding mental illness. It was also proposed that more financial resources should be allocated to improving health promotion in schools in order to ensure that positive attitudes towards mental health are instilled as early as possible within the educational process.

Recommendation 8

Commissioners of mental health services should review services available to meet the needs of people in Northern Ireland who have experienced transgenerational trauma as a result of the Troubles. The evidence from this study supports the recommendation from the recent Commission for Victims and Survivors Report (March 2015), which proposed adopting a coherent strategy and a more comprehensive framework for the delivery of services.

Evidence: The findings indicated that mental health agencies had achieved progress in establishing services to support individuals in Northern Ireland who had been affected by the Troubles. However, the findings indicated that professional services were still struggling to address Troubles-related mental health needs. For example, both mental health professionals and commission staff reported that they had become more aware in recent years of the mental health needs of individuals and families affected by transgenerational trauma. It was felt that mental health services needed to get better at both recognising and addressing needs arising from transgenerational trauma. Mental health commissioners also identified that statutory services had a particular difficulty in addressing the mental health needs of ex-prisoners who had been combatants during the Troubles. It was felt that there was a need for further research to develop knowledge and understanding of why ex-prisoners were generally reluctant to engage with statutory mental health services.

Recommendation 9

Mental health commissioning agencies in the statutory sector should continue to work with voluntary sector organisations to improve collaborative working in the planning and delivery of mental health provision. The DHSSPS should convene a working group with chief executive officers in the voluntary sector to identify the scope for further developing partnership working and collaboration between voluntary organisations in providing services in Northern Ireland.

Evidence: Respondents in both statutory and voluntary sector organisations identified the need for better partnership working between different sectors and service providers. Commissioners expressed concern about the risk of different

voluntary sector organisations duplicating services and competing with each other for increasingly scarce resources. At the same time they acknowledged recent examples of voluntary sector organisations joining together to provide services that had demonstrated the advantages of collaborative working for addressing the needs of service users and carers. Mental health commissioners in the statutory sector felt there was scope for voluntary sector organisations to further develop their role by working together, for example, in providing services to reduce over-dependence on statutory services. It was argued that improving collaboration between all sectors involved in providing mental health services was especially essential in the current climate of financial restraint to ensure that available resources were used as efficiently and effectively as possible.

Recommendation 10

The DHSSPS in conjunction with the HSC Board and Trusts should establish a working group with service users and carers to examine how quality assurance systems in mental health can be further improved.

Evidence: The findings suggest that there is scope for further developing outcome measures and quality assurance systems in mental health. It was felt that current systems did not adequately capture the strengths and limitations of service interventions or provide a mechanism for continuous improvement. It was also felt that recording in mental health had tended to reflect a risk averse culture of practice and there was still a degree of paternalism in the approach taken to information sharing, which was sometimes unhelpful for both service users and carers. It was acknowledged that practice in this area was in the process of changing with the introduction of the *Regional Care Pathway*, which would focus more on outcome measures rather than process measures. However, notwithstanding this development, professionals in both the statutory and voluntary sectors had additional suggestions on how quality assurance mechanisms might be better tailored to mental health services and provide more useful feedback for both individual staff and agencies on what service users felt worked or did not work in the interventions they received.

1 Introduction

Action Mental Health commissioned this study in response to feedback from service users, carers, and staff with experience of mental health services in Northern Ireland (NI). It was designed particularly to give service users a voice for expressing their views on what was working well and areas that needed to be put right. It was felt important to also include mental health commissioners in the statutory sector to ensure there was a complete picture of their views on the effectiveness of services. Whilst this study is a snapshot in time, it is hoped that it will assist decision makers in focusing scarce resources to areas of real need. Although the report identifies deficiencies, it also highlights important aspects of service provision that are going well and good news stories in respect of new developments. Action Mental Health was keen to identify the scope and priorities for further developing mental health services against the backdrop of recent policy developments and the allocation of resources, particularly in comparison to other parts of the health sector in Northern Ireland.

1.1 The Commissioning Organisation: Action Mental Health

From its inception in 1963, Action Mental Health has grown to become one of the largest, voluntary sector organisations in Northern Ireland for people with mental health needs and learning disabilities. The aim of Action Mental Health is to make a positive difference in people's mental health by supporting their mental health and wellbeing through vocational training, supported employment options, personal development, and health and wellbeing programmes, including resilience building. The organisation has 12 service locations in Northern Ireland from where it delivers recovery-focused projects to over 3,000 adults annually. It also provides a range of emotional resilience and suicide/self-harm prevention services reaching over 10,000 young people and adults. In addition, the charity operates three Men's Sheds, a learning disability project, an autism spectrum disorder project, a self-management project, and delivers government employment programmes. Last year just over 20,000 people benefited from these services.

More information on the work and achievements of Action Mental Health is available at www.amh.org.uk.

1.2 The Evaluation Team

This study was completed by an Evaluation Team from Queen's University Belfast, led by Dr George Wilson (Principal Investigator), and supported by Dr Lorna Montgomery, Professor Stan Houston, Dr Gavin Davidson, Dr Colin Harper and Dr Lisa Faulkner.

The report begins with an outline of the methods used to gather and analyse the information provided by participants to address the project's aims. It then presents a brief review of the literature on mental health provision and provides an analysis of mental health policy and funding arrangements. Whilst the analysis of mental health literature and policy focuses on the Northern Ireland context, relevant material is included, where appropriate, from other parts of the United Kingdom and further afield. This is followed by a thematic analysis of the main findings on which recommendations are based. The report concludes with a brief summary highlighting key issues arising from the study.

2 Methodology: The Approach Taken to Conducting the Study

This chapter focuses on the approach used to carry out the study. It begins by outlining the aims and objectives of the project. This is followed by a discussion of the processes employed to address these aims and objectives, which included the completion of semi-structured interviews, focus groups meetings, and an online survey. The chosen methods for data analysis are described briefly and ethical considerations discussed. Finally, the timetable for completion of the study is outlined.

2.1 Aims and Objectives of the Project

The overarching aim was to provide a critical analysis of policy development, the funding context, and key issues in relation to the provision of mental health services in Northern Ireland. In so doing, the following objectives were agreed.

- To explore the perceptions of staff working in frontline services for people with mental health problems in Action Mental Health and other community and voluntary organisations. This focused on how services are provided, including what staff perceived to be working well, existing challenges to the delivery of services, and what needs to happen to ensure that there is adequate provision of services to meet future demand.
- To examine the impact of current community and voluntary services for people with mental health problems on people's lives, from the perspective of staff and service users.
- To collate and critically analyse the views of statutory sector staff involved in commissioning and service development on how mental health services are being provided, including perceived barriers in delivering high quality services based on the needs of the local population.

2.2 Topic Guides and Sampling Methods

Questions and issues deriving from the initial literature review were used to develop topic guides for each evaluation method. In order to maintain consistency in the information gathered across a range of methods, a broad interview schedule was established, which identified the following five topic areas.

- Strengths of service.
- Limitations/gaps in service.
- Developmental priorities.
- Northern Ireland context.
- Any other comments.

These five areas underpinned each of the different data acquisition approaches in this study. Within each area evaluators developed specific prompts depending on the particular interest and expertise of their respondents.

A purposive sample was used to gain a broad and representative sample of key stakeholders. Stakeholder organisations were asked to suggest representatives to participate in the evaluation. Statutory sector commissioners and senior managers were selected to represent the five HSC Trusts, HSC Board, and the DHSSPS. Recruitment to focus group meetings and interviews reflected a gender balance, a range of age groups, and included people from different social and religious backgrounds.

2.3 Key Statutory Sector Stakeholders' Interviews

Seven statutory sector staff involved in commissioning or service development took part in semi-structured interviews conducted between January and February 2015. These included senior managers from all five HSC Trusts in addition to a senior manager from the DHSSPS and HSC Board. Of the seven staff interviewed, all were White and aged between 18 and 65 years; six were male and one was female. The interviews provided an opportunity to discuss how mental health services are being provided currently, including perceived barriers in delivering high quality provision

based on the needs of the local population. The gathered data identified opportunities and indicated priorities for action.

2.4 Focus Groups Meetings

Focus groups meetings were conducted with a range of key stakeholder organisations, including: frontline staff from Action Mental Health; staff from other community and voluntary sector service providers; frontline mental health professionals; service users from Action Mental Health; service users from voluntary organisations other than Action Mental Health; and a carer's group. Meetings with the various groups were used to gather detailed views and opinions of key stakeholders and to establish their perspectives about involvement in services for people with mental health problems. Focus groups were designed to empower and enable respondents by establishing ground rules to ensure that everyone had a voice and all views were taken into account. Respondents were encouraged to provide their views of the strengths, limitations, and future development of mental health service provision.

Focus groups enabled the collection of a wide range of views that could be explored in some depth in the group. However, it was recognised that some people may be reluctant or unable to participate fully in these groups, but would be willing to express their views about current mental health services in a different way. Therefore, an online questionnaire was established using the Survey Monkey (1999-2015; http://www.surveymonkey.com) tool based on the focus group topic guides, to allow people to express their views individually.

2.5 Focus Groups Meetings with Service User or Carer Organisations

There were four focus groups for service users and carers. Non-statutory service user or carer organisations in Northern Ireland were asked to suggest representatives to participate in the evaluation. A member of the Evaluation Team contacted the service user or carer representative and explained the purpose of the project and that potential respondents would be provided with a copy of the 'Participant Information

Sheet'. Representatives were invited to participate by attending a focus group meeting arranged at a convenient time and location. These took place in February, March, and April 2015. Table 2.1 below presents demographic information on respondents who participated in meetings.

Table 2.1. Focus Groups: Participant Characteristics

Category	Number of participants	Gender	Age range in years
Group one: Service users	8	4 males; 4 females	51-60 (n = 4) 41-50 (n = 3) 31-40 (n =1)
Group two: Service users	11	3 males; 8 females	70 + (n = 2) 61-70 (n = 2) 51-60 (n = 2) 41-50 (n = 4) 31-40 (n = 1)
Group three: Service users	3	3 males	40 (n = 1) 60 (n = 2)
Group four: Carers	5	1 males; 4 females	51-60 (n = 3) 41-50 (n = 1) 20-30 (n = 1)

Informed consent was again sought at the beginning of each focus group meeting and staff were asked to complete and sign a 'Participant Consent Form' prior to the meeting taking place. Each focus group meeting was facilitated by a member of the Evaluation Team and lasted for approximately one hour. With the consent of participants, focus group discussions were recorded and subsequently transcribed.

2.6 Focus Groups with Staff from Action Mental Health, Workers from Other Voluntary Sector Organisations, and Other Mental Health Professionals

Four focus groups for people working in current mental health services were conducted in February, March, and April 2015. Groups one and two consisted of 12 members of staff (nine women and three men) from Action Mental Health. Group three consisted of four staff, all women, from other voluntary sector organisations. Group four consisted of three mental health professionals (one woman and two men). Three professionals, one woman and two men, who were not able to attend the focus group were interviewed individually. All focus group participants were White and aged between 18 and 65 years; more specific demographic details were not gathered, rather participants' were selected purposively to reflect diverse organisational and professional backgrounds. Mental health professionals were approached through their professional associations, including the **N**orthern **I**reland **A**ssociation of **S**ocial **W**orkers (NIASW), **R**oyal **C**ollege of **P**sychiatrists (RCP), **R**oyal **C**ollege of **N**ursing (RCN), **C**ollege of **O**ccupational **T**herapists (COT), and the **B**ritish **P**sychological **S**ociety (BPS). Mental health staff and professionals who agreed to participate were sent a Participant Information Sheet and subsequently contacted by a member of the Evaluation Team to arrange their attendance at a focus group meeting or interview. Informed consent was again sought at the beginning of each focus group meeting and staff were asked to sign a Participant Consent Form prior to the meeting taking place. Each focus group meeting was facilitated by a member of the Evaluation Team and lasted for approximately one hour. With the consent of participants, focus group discussions were recorded and subsequently transcribed.

2.7 Interviews with Service Users and Staff from Action Mental Health

Dyad interviews were planned with Action Mental Health service users and staff. Semi-structured interviews were conducted with five service users who attended training services at Action Mental Health. These took place in January 2015. The key workers of these five service users were also interviewed. However, as one key worker fulfilled this role for three service users, only three key workers were interviewed. All five service users that were interviewed were White. Additional demographic characteristics are displayed in Table 2.2.

Table 2.2. Interviews: Participant Characteristics

Category	Number of participants	Gender	Age
Service users	5	4 females 1 male	51 to 60 years (n = 3) 41 to 50 years (n = 2)
Key workers	3	1 female 2 males	31 to 40 years (n = 1) 41 to 50 years (n = 1) 51 to 60 years (n = 1)

Senior management staff from Action Mental Health identified an appropriate support person within the organisation with whom the participant could meet following the interview, if required. With consent, interviews were recorded and subsequently transcribed. Conducting semi-structured interviews with these participants enabled the gathering of rich data about the quality of current services provided by Action Mental Health and how these fitted into the wider provision of mental health services.

2.8 Online Survey

The evaluation included a survey that was conducted using the online programme, Survey Monkey (1999-2015, http://www.surveymonkey.com). The survey comprised a series of questions designed to capture certain characteristics of the respondents and their views and opinions of current community and voluntary

service provisions for people with mental health problems in Northern Ireland. The link to the online questionnaire was promoted through the Action Mental Health website and was active over a four-month period (December 2014 to March 2015). In total, 276 responses were received.

2.8.1 Respondents' Profile

Respondents were asked to indicate their role in relation to the mental health arena. Table 2.3 shows that one third of respondents (33%) self-identified as service users, a further 25% were mental health professionals within the voluntary sector, and 18% were mental health professionals from within the statutory sector. Only 9% of respondents self-identified as a being a 'carer'. The remaining 15% identified as 'other' and included a General Practitioner (GP), a Physiotherapist, student nurses/health workers from both the voluntary and statutory sectors, as well as former service users, those in advocacy roles, and members of the public with a general interest in mental health.

Table 2.3. Respondents by Self-Identified Category

Categories	Response %
Service user	33
Carer	9
Mental health professional (voluntary sector)	25
Mental health professional (statutory sector)	18
Other	15

Almost all respondents (98%) described their ethnicity as White, and the overwhelming majority were female (74%). Table 2.4 also demonstrates that there is a preponderance of women across all categories, which is particularly pronounced within the categories of 'service users' and 'mental health professionals (voluntary sector)'.

Table 2.4. Gender of Respondents by Self-Identified Category

Categories	% Females	% Males
Service user	71	29
Carer	79	21
Mental health professional (voluntary sector)	77	23
Mental health professional (statutory sector)	72	28
Other	75	25

The age of respondents was spread largely across several groupings as detailed in Table 2.5. A similar pattern was found within the categories of type of respondent (see Table 2.6).

Table 2.5. Age of Respondents

Age of respondents (in years)	Response %
18 to 24	8
25 to 34	25
35 to 44	25
45 to 54	29
55 to 64	11
65 to 74	1
75 or older	1

Table 2.6. Age of Respondents by Self-Identified Category

	What is your age? (in years)						
Category	**18-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75 +**
Service user	16	24	14	27	6	0	0
Carer	1	4	7	3	5	2	0
Mental health professional (voluntary sector)	2	16	17	23	11	0	0
Mental health professional (statutory sector)	2	16	12	15	5	0	0
Other	1	8	18	8	4	0	1

2.9 Data Analysis Approach for Qualitative Methods

Evaluation Team members collated the qualitative data from the focus groups and interviews and individually applied interpretive validation techniques to code this information. A process of co-analysis was then used to construct a thematic analysis of these narratives using selected quotations to illustrate common and divergent themes.

2.10 Ethical Considerations

Informed consent is key to undertaking ethical interviews and focus groups, and to facilitate this, participants were sent a Participant Information Sheet prior to agreeing to involvement. This highlighted the aims of the project, the contact details of the Principal Investigator, the types of issues that would be addressed in the interview or focus group (or both), and explained the recording mechanism for the interview or focus group.

Concern for the welfare of the participants was paramount, especially as the project focused on sensitive topics around mental health and provision of services. Service user, carer, and professional representatives were advised at the start of interviews or focus groups that they could withdraw at any time, and pause or end their participation in the evaluation without having to give a reason. The Evaluation Team

had prepared a list of appropriate support services, which were available for any focus group participant, if needed. The interviews and focus group meetings were facilitated by experienced qualitative evaluators, all of whom had previously worked as social workers.

Participants were ensured confidentiality of all information provided during focus group meetings or interviews, with the only exceptions, as outlined in the information sheet, being if someone's safety was identified as being at risk or where serious criminal activity was disclosed. Participants were also assured that any cited comments would not be attributed to a particular individual, and to this end, the following terms were used to refer to the designation of informants in the write up of the report.

- Mental health commissioner(s).
- Mental health professional(s) (statutory).
- Mental health professional(s) (voluntary).
- Service user(s).
- Carer(s).

The study was approved by the Ethics Committee of the School of Sociology, Social Policy and Social Work, Queen's University Belfast.

2.11 Data Protection

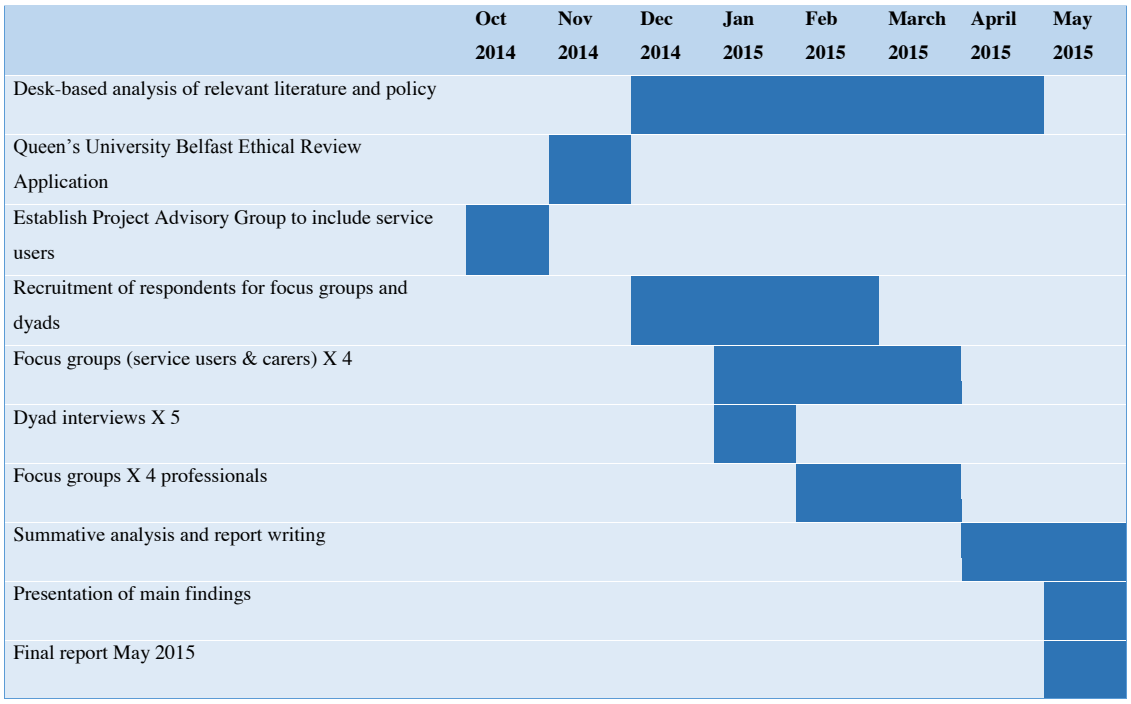
The Evaluation Team adhered to data protection practices. The texts of any transcriptions were anonymised using a unique code, and files were kept on a password protected computer and USB (**u**niversal **s**eries **b**us) flash drive.

2.12 Ensuring Trustworthiness

The following measures assured the trustworthiness of the approaches described above.

- Data acquisition methods were triangulated.
- A systematic procedure for analysing the data was adopted.
- The preliminary findings were critically discussed at various points with the sponsors and among the evaluators.
- Respondent triangulation was utilised in order to gather the perspectives of a range of stakeholders.
- The interviewers adopted a standardised approach using a structured topic guide, which focused on the five areas mentioned above.

2.7. Timetable for the Evaluation



3 Literature Review

3.1 Introduction

The literature review sought to contextualise the analysis of findings and identify key themes and issues of relevance to the development of statutory and voluntary mental health provision in Northern Ireland.

A search for relevant academic literature was completed on 10 November 2014. The parameters of the search were as follows.

1. The search included the following online databases.
    a. Ovid Medline.
    b. Embase.
    c. SocINDEX.
    d. EconLit.
    e. PsycINFO.
    f. Centre for Reviews and Dissemination.
    g. Cochrane Library.
2. The search initially focused on literature in Northern Ireland published since 2004. The search strategy used the following key terms.
    a. 'Mental health' AND 'Northern Ireland' AND 'policy'.
    b. 'Mental health' AND 'Northern Ireland' AND 'service' OR 'services'.
    c. 'Mental health' AND 'Northern Ireland' AND 'carers'.
    d. 'Mental health' AND 'Northern Ireland' AND 'recovery'.

    However, this strategy returned a small number of records, and it was decided that a more general search was required. Therefore, all of the databases were researched for any items relating to the following two terms only.
    e. 'Mental health' AND 'Northern Ireland'.
3. A total of 40 records were obtained.

3.2 Analysis of Northern Ireland Literature

There is limited academic research relating to mental health in Northern Ireland. There is a recognised lack of resources for, and interest in, mental health research in general[1], and unsurprisingly, this pattern is reflected in research relating to Northern Ireland.

Key research areas for Northern Ireland are visible in the results of the literature search. Using broad categories, it is possible to see the pattern of where post-2003 research relating to mental health has focused, and an overview of these areas is indicated in Table 3.1. Where an item clearly related to more than one topic, it was counted twice (e.g. suicidal young men).

Table 3.1. Results of Search Strategy

Topic: 'Mental health and …'	Number of items
Northern Ireland conflict	9
Services	8
Specific population group(s)	7
Mental wellbeing	6
Practice	4
Suicide	4
Equality, discrimination, human rights or stigma	4
Work/employment	2
Criminal justice	1
Specific mental health condition(s)	1

Not all of research identified in the literature review produced clear conclusions. From that which did, a sample of some of the key findings is outlined below. (This bulleted list is provided for indicative purposes only and consideration should be given to the content and adequacy of the full research as published).

[1] Lock, H. (2015) *Mental health research: Underfunded and failing to attract young academics*, *The Guardian*, 18 February 2015. Available at: http://www.theguardian.com/higher-education-network/2015/feb/18/mental-health-research-underfunded-and-failing-to-attract-young-academics?CMP=share_btn_tw

- The odds of having a suicide plan are significantly higher for people with conflict-related traumatic events compared to those with only non-conflict-related events and no traumatic events (O'Neill et al., 2014).
- Attempts to address needs arising as a result of the 'Troubles', and more general mental health promotion strategies, have, to some extent, developed in parallel and it may be important to integrate these efforts, possibly through routine screening for conflict-related mental health issues in primary care and mental health services (Davidson and Leavey, 2010).
- Forgiveness and collective guilt can act as mediators in the relationship between impact of ethno-political conflict and mental health at the group level, and thus are central to the reconciliation process (Myers et al., 2009).
- Psychiatric morbidity rates for adults in Northern Ireland are comparable to other parts of the United Kingdom and individuals in Northern Ireland use a range of coping strategies to moderate the impact of the conflict in everyday life (Murphy and Lloyd, 2007).
- Direct experience of violence and poverty increase the risk of post-traumatic stress disorder (PTSD), whereas strong national identification appears to reduce this risk (Muldoon and Downes, 2007).
- The 'Pyramid Plus' psychosocial intervention for shy, withdrawn primary school children helps to alleviate internalisation problems and, at least initially, has a positive impact on social re-integration (McKenna et al., 2014).
- Presentation to primary care may offer an opportunity for intervention prior to suicide and gendered patterns in service use prior to death should be considered in suicide prevention programmes (O'Neill et al., 2014).
- The rate of adolescent self-harm in Northern Ireland is lower than elsewhere in the United Kingdom/Ireland and exposure to the Northern Ireland conflict is associated with self-harm alongside established risk factors (O'Connor et al., 2014).
- Whilst mental health problems are highly prevalent in Northern Ireland, a large proportion of people experiencing problems do not seek treatment (Bunting et al., 2013).

- Individuals who have experienced conflict are more likely to have had an anxiety, mood or impulse-control disorder and treatment delays are substantial for anxiety and substance disorders (Houdmont et al., 2012).
- Evidence from the **Y**oung **L**ife and **T**imes (YLT) survey of 16-year-olds shows that same-sex attracted young people suffer poorer mental health (Schubotz et al., 2011).
- Structurally integrated health and social services in Northern Ireland are more conducive towards integrated working compared to those in England (Reilly et al., 2004).
- Opportunities exist within the current change process for service users and social workers to build closer alliances in working together to reconstruct practice, safeguard human rights, and develop innovative alternatives to a traditional biomedical model of treatment (Wilson and Daly, 2007).
- Assertive outreach appears to be more successful at reducing perceived coercion, minimizing the need for coercive strategies, engaging high-risk clients, and reducing inpatient bed use (Davidson and Campbell, 2007).

3.3 Key Themes Arising from the Northern Ireland Literature

The valuable work carried out since 2004 provides a range of findings with respect to mental health in Northern Ireland and highlights a number of key issues of relevance to this study.

3.3.1 Northern Ireland's Distinctive Health and Social Care Needs

In comparison with other parts of the United Kingdom, it is evident that Northern Ireland continues to have a distinctive profile of mental health needs characterized by high levels of socio-economic deprivation and the deleterious effects of over thirty years of civil and political conflict (Bunting et al., 2013; Davidson and Leavey, 2010). The associated human capital costs of mental health problems, including the numbers of people claiming incapacity benefit, loss of employment through mental illness, and reduced quality of life have also been found to be significantly higher in Northern Ireland (Northern Ireland Association for Mental Health, 2004).

3.3.2 Impact of the Bamford Review (2007)

The Bamford Vision for improving mental health in Northern Ireland aimed to develop a comprehensive range of services that would support people with mental health needs to achieve their maximum level of functioning and lead as independent lives as possible (Bamford, 2007). A main component of the Bamford Vision was the need to promote a system of care and support based on recovery approaches, particularly for people with complex needs. It was envisaged that these approaches would be the main vehicle for providing an early and appropriate service response. The aim was to ensure that services would support people with mental health needs to plan and build a satisfying life, engage in work or other meaningful activities, and contribute to and participate in society. A key question for this study is to what extent do different stakeholders feel the Bamford Vision has been realised and the goals and objectives for addressing Northern Ireland's distinctive profile of mental health needs been met.

3.3.3 Impact of the Recession and Financial Restraint

Whilst there is some evidence to suggest that progress has been made in realising the actions for improving mental health services, as outlined in the Bamford Vision, concerns remain about the continuing impact of health inequalities and the legacy of the Troubles on the population of Northern Ireland (DHSSPS, 2011; 2012). Also, there has been little or no study of how the economic recession and the current strong emphasis on financial restraint in health and social care commissioning have impacted on the development of mental health services. In essence, we have little empirical knowledge of the impact of these factors on service users in Northern Ireland, or the ability of frontline staff to meet their needs. Indeed, it is evident from the review of literature that there has been a lack of ongoing, systematic mental health research in and for Northern Ireland that can provide a strong evidence base for legal, policy, and service development. Further research and evaluation is essential in order to examine what needs to be done to sustain and develop statutory and voluntary service provision.

3.4 Analysis of Key Themes Highlighted by UK and International Literature

The following section presents a brief analysis of recent UK and international literature relating to the development of mental health services. Whilst not exhaustive, the analysis further contextualises the current study by identifying themes and issues emerging from recent published work that are of significance to an evaluation of mental health services.

3.4.1 Mental Health Policy: Strategic Challenges

Knapp et al. (2007) have argued that having a national policy and strategic framework for mental health is essential for both raising awareness and securing the resources necessary to deliver effective services. Whilst, from this perspective, the Bamford Review and subsequent policy developments in Northern Ireland can be considered an advantage, it is clearly essential for such policies to be regularly updated to ensure they remain fit for purpose. (Given the importance of this topic in relation to service development, Chapter Four of this report provides a comprehensive examination of recent mental health policy development in Northern Ireland and an examination of the associated costs).

Alongside the increased prevalence of mental health problems, perhaps the most significant strategic challenges for governments across Europe focused on how to replace institutional hospital-based care with effective community-based provision (Knapp et al., 2007). More recently, the scale of this challenge has undoubtedly been significantly increased by the economic recession and the climate of financial restraint, which has impacted on the scope for service development in health and social care. A recent study by Evans-Lacko et al. (2013) argued that the economic recession presented particular problems for people with mental health problems who could be at higher risk of losing their jobs and less likely to regain employment, which is regarded as a key component in recovery from mental health issues. Together with the financial consequences of losing a job, it is also clear that the additional stress involved for service users and their families is likely to have a negative impact on mental health (Evans-Lacko et al., 2013).

3.4.2 Developments in Mental Health Services, Costs, and Limitations of Provision

A number of studies have indicated the high social and economic costs of mental health problems (Organisation for Economic Co-ordination and Development (OECD), 2014; Sainsbury Centre for Mental Health, 2007). Generally, expenditure across a range of OECD countries has been rising but some areas have continued to experience underinvestment in mental health services in comparison with other aspects of health expenditure (McDaid et al., 2005; OECD, 2014). Also, although recognition and treatment interventions have generally improved, the OECD (2014) report concludes that deficiencies in services and under-treatment of mental health problems remains a significant factor contributing to the high economic and social costs of mental health problems. In the United Kingdom context, a study by Layard et al., (2012) highlighted massive funding and resource inequalities in the way the NHS (**N**ational **H**ealth **S**ervice) treats mental illness in comparison with physical illness. The report concluded that whilst mental illness accounts for 23% of the total burden of disease, it receives only 13% of NHS health expenditure in spite of the existence of cost-effective treatments (Layard et al., 2012). A recent review of mental health services across the United Kingdom reported that, although community-based services had improved in some areas, there were substantial gaps and limitations in provision and concern was expressed that population growth was likely to exacerbate such deficiencies in future (Mental Health Foundation, 2013). Areas requiring further investment and improvement included crisis care and support, access to psychological therapies, services for children and young people, and services for older people (Mental Health Foundation, 2013).

3.4.3 Mental Health Promotion, Early Intervention, and Prevention

There is international recognition that investing in the development of mental health provision, including early intervention and preventative services, is of value not only in improving care and treatment for individuals and families but also in reducing the economic costs associated with mental health problems (Kelly et al., 2007; Knapp et al., 2011; Valmaggia et al., 2009). A number of studies have made the case for prioritising investment in mental health promotion given its value in mental illness

prevention (Friedli and Parsonage, 2007; Knapp et al., 2011; Merzel and D'Afflitti, 2003). However, it is also acknowledged that mental health services need to get better at measuring the effectiveness of such initiatives and mental health services more generally. Knapp et al. (2001) have argued there is a need to develop outcome measures that are more specific to mental health, and as part of this process, it will be essential to improve data collection and analysis systems. In this context it has been argued that systems for measuring quality "must move beyond traditional health indicators to encompass social outcomes, such as education, employment, housing, and social inclusion" (OECD, 2014, p. 7).

3.4.4 Integration and Collaborative Working

Whilst the value of effective collaboration and integration between different services involved in planning and delivering health and social care appears self-evident, and has been a key aspiration of different governments in the United Kingdom for many years, inter-agency tensions seem to be endemic throughout the NHS (Plamping et al. 2000). Snape (2003) has observed that, although the introduction of the **C**are **P**rogramme **A**pproach (CPA) in Britain in 1991 improved multidisciplinary working in services for older people and those with mental health problems, it did not lead to a fully integrated service. In this context, Northern Ireland has a major advantage in that health and social care services have been structurally integrated since 1973, with one employer, shared aims and objectives, and one source of funding (Ham et al., 2013). Northern Ireland's integrated structures would appear to make it well positioned to offer seamless mental health services and continuity of care from hospital into the community. In essence, Northern Ireland's integrated structures should also mean that it is well placed to deliver on *Transforming Your Care: A Review of Health and Social Care in Northern Ireland* - a new policy initiative aimed at delivering care closer to home to suit service user and carer needs in different programmes of care, including mental health (DHSSPS, 2011; Ham et al., 2013). However, as Ham et al. (2013) have observed, the area of mental health is not often viewed as a priority within health and social care and, although the structures for integration are in place, "the integrated health and social care system has not realised its full potential and the opportunities provided by the structural organisation have not been fully exploited" (p. 21). More recently, the Mental Health Foundation

(2013) study of mental health services across the United Kingdom reported that mental health care was often experienced as disjointed and lacking in continuity, leading to problems for service users in accessing appropriate services to meet their needs. One of the main recommendations of this study was that more priority needed to be given to improving integrated care and maximising opportunities for ensuring that the health and social care workforce was better informed about the value of collaborative working, including the skills that different disciplines could bring to enhancing care and treatment (Mental Health Foundation, 2013).

3.4.5 Service User Involvement

Service user involvement in mental health can mean a wide range of activities from partnership working at the individual care level to inclusion in the planning, evaluation, and research of services (Tait and Lester, 2005). In the United Kingdom context, there has been widespread support for greater service user involvement, both at individual and at peer support level, but also increasingly at strategic and leadership levels within organisations that commission and provide mental health services (Gilburt et al., 2014; Wilson and Daly, 2007). Nevertheless, Peck et al. (2002) have argued that it is important in evaluating service user involvement to consider the type of interaction, from receiving information through being consulted to influencing or having control. Although there is abundant literature indicating how these forms of empowerment can be achieved across these levels, there are different perspectives as to what extent service user involvement has become embedded in mental health policy and practice (Faulkner, 2009; Kalathil, 2013; Wilson and Daly, 2007).

3.4.6 Reducing Stigma and Discrimination

A study by the Mental Health Foundation (2013), which examined the state of mental health services across the United Kingdom, found that stigma and discrimination continued to be significant features of service user and carer experience, which impacted negatively on their health and wellbeing and social inclusion. They found that stigma experienced by respondents in their study tended to fall into two areas – stigma from the public and stigma from health professionals –

both of which impacted negatively on service users, carers, and staff alike. Whilst the stigma experienced by mental health service users has been well documented (Lee et al., 2005; Wilson and Daly, 2007), stigma from health professionals is less well researched. A study by Bolton (2012), for example, reported that psychiatric staff tended to experience stigmatising attitudes from general hospital colleagues.

The evidence indicates that public educational interventions can have a positive impact on reducing stigma and associated discrimination experienced by service users and carers (Couture and Penn, 2003). A study by Pinfold et al. (2003), which evaluated educational interventions in secondary schools in the United Kingdom, also found that short educational workshops can produce positive changes in participants' reported attitudes towards people with mental health problems. This study reported that attendance by secondary school students at two mental health awareness workshops tended to increase mental health literacy and challenged negative stereotypes associated with severe mental illness (Pinfold et al., 2003). However, although noting grounds for optimism, the Mental Health Foundation (2013) study of the United Kingdom context found that progress towards reducing stigma had been slow and it was concluded that sustained long-term effort would be required to reduce its pervasive impact.

3.4.7 Promoting Recovery

The importance of promoting a recovery approach in mental health, including how it should be defined (Shepherd et al., 2008), and how best to develop it in practice (Roberts and Hollins, 2007), has been widely debated in both the UK and international literature. In the United Kingdom, a recovery focused approach has increasingly been viewed as essential for ensuring mental health services are fit for the 21st century. The literature highlights the importance of obtaining the views of service users on how this approach is actually implemented in practice (Shepherd et al., 2008; 2010), and how its impact is evaluated (Care Services Improvement Partnership et al., 2005). Whilst the definition of what constitutes a ‘recovery approach’ is contested, there is a general consensus that a central tenet should be shared decision making - ‘no decision about me without me’ (Department of Health, 2010). Also, it has been argued that shared decision making in mental health is likely

to have a positive impact on promoting quality of life and achieving better health outcomes (South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, 2010). Moving away from a medical model of care to one that promotes a recovery ethos involves acknowledging service users and carers as equal partners in decisions about planning and delivering mental health services (Wilson and Daly, 2007). However, as the Mental Health Foundation (2013) report argues, providing a more personalised service in mental health also involves building a workforce that "has a truly participative and listening approach to patient care, as well as skills helping people who may lack capacity to make decisions" (p. 7).

4 Review of Mental Health Policy and Funding Arrangements

4.1 Introduction

The policy context for mental health interventions and the development of mental health services in Northern Ireland is complex and multi-faceted (Prior, 1993; QUB Budget Analysis Project, 2013). The situation in Northern Ireland is unusual in terms of:

- the numbers of people experiencing mental health issues;
- the social determinants of those mental health issues;
- its integrated health and social care system; and
- its lack, until relatively recently, of local systems of government positioned to develop locally appropriate solutions.

There are multiple policy processes relevant to mental health issues in Northern Ireland, but this brief overview focuses only on the following key policy processes and their outcome documents.

- The Bamford Review of Mental Health and Learning Disability (Northern Ireland) as the overarching vision for mental health services in Northern Ireland (see Bamford, 2005).
- The *Programme for Government 2011-2015* as the highest level political statement of policy priorities for mental health (see Northern Ireland Executive, 2012b).
- The Transforming Your Care reform agenda for health and social care in Northern Ireland as the clearest statement of the challenges facing health and social care and the solutions needed to address these (see DHSSPS, 2011).
- Funding for mental health.

This overview outlines the policy content in each of these four policy areas with respect to mental health and identifies the key policies contained in them along with the funding issues they explicitly raised. It does not seek to evaluate the extent or effectiveness of the implementation of those policies in a comprehensive manner.

4.2 The Vision for the Future: The Bamford Review of Mental Health and Learning Disability (Northern Ireland) and the Response of the Northern Ireland Executive

The Bamford Review of Mental Health and Learning Disability (Northern Ireland) was established in 2002 to carry out an independent and comprehensive review of the law, policy and provisions, which affected people with mental health needs or a learning disability in Northern Ireland. It completed its task on 16th August 2007[1] and its work resulted in a set of 11 published reports. Mental health organisations, mental health professionals, service users, and carers were involved in the overall work of the Bamford Review and through membership of its various committees. In October 2009, the DHSSPS published the final Response: *Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability—Action Plan 2009*-2011 (hereafter referred to as the *Action Plan 2009-2011*).

The *Action Plan 2009-2011* stressed that:

> Future services for mental health needed to support people to live as full a life as is possible through:
>
> - early intervention and support;
> - integrated care planning with the involvement of individuals, their families, and carers;
> - the promotion of independence, personal fulfilment and, where possible, recovery;
> - effective interagency working and partnership with community, voluntary and private sectors, appropriate to the needs of individuals;
> - the recognition of the needs of families and carers throughout the lifecycle of the individual and the importance of effective transition and succession planning, information, and advice;

[1] Material relating to the Bamford Review, including its 'Terms of Reference' and the reports it published are available at dhsspsni.gov.uk/bamford

- development of services, including specialist services, which will be underpinned by standards outlined in mental health and learning disability service frameworks; and
- a focus on performance improvement to ensure that the patient/client experience and the quality of care delivered to individuals, families, and carers is of the highest possible standard. (DHSSPS, 2009, pp. 6-7).

4.3 Resourcing the Changes

In its Report on Adult Mental Health Services, the Bamford Review (2005) had commented on what was needed to resource the changes. This is the most substantive comment on funding for mental health services in the published reports and is worth quoting in full:

> The programme of change that is required for adult mental health services in Northern Ireland represents major challenges at both regional and local levels. The proposals have major implications for future Health and Personal Social Services mental health revenue and capital investment programmes and for future estate requirements. With anticipated reorganisation and reconfiguration, local providers must ensure that resources follow service users.
>
> These changes cannot occur without protected investment from government to drive local service development. The need for additional investment is justified on a number of well recognised factors:
>
> - socio-economic deprivation in Northern Ireland is significantly higher than in Great Britain;
> - the rurality of our population distribution is contributing to higher costs;
> - the health of our population is generally poorer compared to Great Britain;
> - the link between deprivation and health and social care need is particularly strong in the mental health programme of care;
> - the aftermath of the troubles is still being experienced, for example, in terms of mental health problems and needs and this is likely to continue for many years;

- investment levels in mental health services have not kept pace with other areas of the UK and there are significant gaps in service provision; and
- as a result of a general failure to replace or redevelop aging estate and to address a growing backlog across Northern Ireland, a significant capital investment in mental health services is required.

This situation has arisen in the context of relatively low Health and Personal Social Services management and administrative costs compared with Great Britain. Although hospital productivity has doubled over the last ten years, the model of care in Northern Ireland is accepted to be too reliant on inpatient care. New funding needs to be matched by rigorous performance management at all levels to ensure the introduction of the essential new services and to secure a modern service, fit for the needs of our population in the early part of the 21st century.

The Bamford Review recommends the establishment of a Mental Health Modernisation Programme, essentially a financial plan that brings together the service recommendations of the Strategic Framework and matches them with both the necessary funding streams and the performance milestones that will guide local investment (See Chapter Eight).

The service elements that will require investment include:

- User and Carer involvement and support;
- Advocacy services;
- Independent sector services;
- Mental health promotion;
- Primary care mental health services, including Early Intervention;
- Community mental health services, including Community Mental Health Teams, Home Treatment Teams, and Crisis Response teams;
- General Hospital Psychiatric Liaison services, including Accident and Emergency (A&E) services;
- Perinatal services;
- Crisis services, including day hospital care;

- Services promoting recovery, including the needs of service users with challenging behaviour;
- Dual Diagnosis services;
- Community accommodation;
- Homelessness support;
- Day care, including prevocational training and employment;
- Prescribed drugs;
- Psychological Therapy services;
- Specialist services, including services for people with eating disorders, people with acquired brain injury or progressive brain disease, personality disorders, psychological trauma, disorders of gender and sexuality, women with perinatal mental health problems, people with Asperger's syndrome/ high functioning autism, and deaf people with mental health needs; and
- Workforce training needs'. (Bamford Review, 2005, pp. 138-140).

4.4 Human Rights and Equality

In commenting on human rights and equality principles, which lie at the centre of the Bamford Vision for law, policy and service delivery, the *Human Rights and Equality Report* was emphatic in calling for greater resources for mental health and learning disability as a human rights and equality issue (Bamford Review, 2006a). Human rights and equality were understood by the Bamford Review as the basis of its work, as the basis for the delivery of mental health services, and as the basis for the reform and increased resourcing of services.

4.5 Forensic Services, Mental Health Issues in Older Age, Child and Adolescent Mental Health Services

The Forensic Services Report consistently stresses the need for adequate resources for health and social care to be able to work efficiently and to full effect with the criminal justice system. (Bamford Review, 2006b, pp. 128-40). The need for investment to deliver on the recommendations of the Bamford Review was also

stressed in the Report on Mental Health Issues in Older Age (Bamford Review, 2007b).

The report on CAMHS stresses that within the overall allocation of resources to mental health, there is a lack of equity in terms of the share allocated to child and adolescent mental health whilst also acknowledging difficulties in determining exactly what resources were allocated to these services (Bamford Review, 2006c, p. 63).

The Bamford Review also expressed concern as regards how issues of effective use of resources can arise in the context of multiple programmes of care. Combined with issues of equitable allocation of resources based on accurate assessment of population need, the possibility of inequitable distribution of resources within the overall mental health budget is an important consideration. Any relative or absolute increase or decrease in spending could impact significantly in different ways within the different components of mental health provision.

4.6 Evaluation of the Bamford Review Action Plan 2009-2011

An *Evaluation of the Bamford Review Action Plan 2009-2011* identified the following key challenges in its delivery:

- establishing a stepped care approach to service provision;
- enhancing the range of options available to primary care professionals to deal with the mental health needs presenting to them;
- improving access to psychological therapies;
- streamlining access to all mental health services;
- providing home-based care and support as the norm for the delivery of mental health services;
- applying a systematic approach to enable the recovery of people with long-term conditions;
- building up the range of specialist mental health services required to meet need; and
- re-designing and extending roles and retention of an effective workforce. (DHSSPS, 2012a, p. 7)

In the main, the quantifiable targets set for mental health actions were seen as being achieved (eight out of 11) (see Annex A, DHSSPS, 2012a). Of particular note is that re-direction of HSC funding towards community-based services (target 60% of HSC spend on mental health services should be on community services) was not achieved with mental health community funding in 2010/11 being 53%. Whilst all of the 'Mental Health Actions' have resource implications, the only actions that related directly to allocation of resources are those on the allocation of resources to community rather than hospital services. Such targets can of course be achieved even in the context of absolute or relative reduction, or both, in overall spend on mental health services as a whole.

4.7 Delivering the Bamford Vision: Action Plan 2011-2015

In November 2012, the DHSSPS published a second action plan, referred to here as *Action Plan 2011-2015* (DHSSPS, 2012b). The tasks in this plan consist of: uncompleted actions carried forward from *Action Plan 2009-2011*; actions which were a consequence of completed actions from the *Action Plan 2009-2011* (see DHSSPS 2012a); and new areas of work, including some highlighted in the 2008 consultation on the Northern Ireland Executive's Response. The only action that relates directly to funding is to 'Re-direct HSC funding towards community based services' (DHSSPS, 2012b, p. 57). This is to be led by the HSC Board and has the 'required output' that '60% of HSC spend on mental health services should be on community services by March 2015' (DHSSPS, 2012b, p. 57). There are no actions relating to a goal of overall HSC spend on mental health services. This is not surprising in the light of *Action Plan 2011-2015* emphasizing that:

> '…the actions in this Plan also take account of the financial outlook. Only actions which can be taken forward within the existing budgetary allocations are committed to in the Plan.' (DHSSPS, 2012b, p. 16).

The current Bamford Action Plan finished in March and no evaluation has been published so it is likely that no decision has been taken on whether to extend it or not. This could allow a policy vacuum to develop and momentum and service developments, as overseen through the Bamford Monitoring group, may be lost.

4.8 Response of the Northern Ireland Executive to the Action Plan 2011-2015

In November 2013 the DHSSPS produced a Monitoring Report on delivery of the *Action Plan 2011-2015* (DHSSPS, 2013). Sixty-three actions (83%) were coded green, meaning 'on target'; 13 actions (17%) were coded amber, meaning at risk/delayed; and none were coded red or unlikely to be achieved (DHSSPS, 2013, p. 4). Some of the 'amber' actions related to strategic areas such as mental health promotion, suicide prevention, and mental health/capacity law reform. With respect to mental health promotion and suicide prevention, the issue was related to the development and implementation of the relevant strategy.

As *Action Plan 2011-2015* does not contain any actions relating to a goal of overall HSC spend on mental health services, there is no monitoring of such spend in the report (see DHSSPS, 2012b).

4.9 The Politics of Delivering Mental Health: The Programme for Government 2011-2015

The *Programme for Government 2011-2015* was endorsed by the Northern Ireland Assembly on 12 March 2012 (see Northern Ireland Executive, 2012b). It consists of a set of 'Priorities', each with 'Key Commitments' and associated 'Milestones'. Mental health features in the *Programme for Government 2011-2015* in several places:

> Priority one relates to 'Growing a Sustainable Economy and Investing in the Future' and this is stated to mean 'acting to improve the mental health and wellbeing of our people.' (Northern Ireland Executive, 2012b, p. 30).

The relevant 'Key Commitment' is:

> Allocate an increasing percentage of the overall health budget to public health (DHSSPS) (This should contribute to society and the economy by tackling disadvantage.) (Northern Ireland Executive, 2012b, p. 35)

This 'Key Commitment' has an associated 'Milestone' for '2012-13' to:

> Strengthen the cross sectoral/cross departmental drive on improving health and mental wellbeing and reducing health inequalities by setting new policy direction and associated outcomes based on the most recent bodies of evidence available (Northern Ireland Executive, 2012b, p. 35).

In spite of the 'Milestone' for '2012-13' being to 'Strengthen the … drive on improving health and mental wellbeing' (Northern Ireland Executive, 2012b, p. 36), mental health does not feature explicitly in the update.

Priority two relates to 'Creating Opportunities, Tackling Disadvantage, and Improving Health and Wellbeing' and is stated to mean 'cross-departmental work to reduce suicides' (Northern Ireland Executive, 2012b, p. 36).

Priority three relates to 'Protecting Our People, the Environment and Creating Safer Communities'. It is stated that this 'focuses on making real improvements to people's health and wellbeing, both physically and mentally…' (Northern Ireland Executive, 2012b, p. 42). Further, that this means 'improving health (mortality and morbidity) and wellbeing (including social inclusion and safeguarding)', and 'strengthening legal safeguards for people who lack capacity to take decisions themselves' (Northern Ireland Executive, 2012b, p. 42). Building blocks include 'Investing for Health' (p. 43).

Priority five relates to 'Delivering High Quality and Efficient Public Services' which means 'improved access to services and information' (Northern Ireland Executive, 2012b, p. 52). There are two relevant 'Key Commitments':

> Improve patient and client outcomes and access to new treatments and services (DHSSPS) (Northern Ireland Executive, 2012b, p. 55).

> Reconfigure, reform and modernise the delivery of Health and Social Care services to improve the quality of patient care (DHSSPS) (Northern Ireland Executive, 2012b, p. 55).

The 'Milestones' in connection with this 'Key Commitment' relate to Transforming Your Care:

2012-13: Development of a clear implementation and Population plan to ensure delivery of the new model of care as set out in the *Transforming Your Care* report.

2013-14: As part of a shift in the delivery of services to primary and community settings reduce by 2013/14 the number of days patients stay in acute hospitals unnecessarily (excess bed days) by 10% compared with 2011/12.

2014-15: Secure a shift from hospital based services to community based services together with an appropriate shift in the share of funding in line with the recommendations of *Transforming Your Care*. (DHSSPS, 2013, p.55).

From the above references, it is clear that mental health does not feature largely in the *Programme for Government 2011-2015* nor does it have much presence in recent assessments of progress (see Northern Ireland Executive, 2012b). This is in spite of consultation responses on the *Draft Programme for Government 2011-2015* having made clearer and more substantive points for inclusion (see Office of the Minister and Deputy First Minister, 2012).

4.10 The Process of Securing Change*:* Transforming Your Care

The *Action Plan 2011- 2015* positions the *Transforming Your Care* policy agenda as a key context for further progression of the recommendations of the Bamford Review (see DHSSPS, 2011; 2012b).

Transforming Your Care: A Review of Health and Social Care in Northern Ireland has many parallels with the Bamford Vision in respect of mental health and learning disability service provision and enhancement, including the following:

- early intervention and health promotion;
- a focus shift to community care;
- promotion of recovery practices;
- personalisation of care;
- resettlement;
- service user and carer involvement;

- advocacy;
- provision of clearer information; and
- respite provision (see DHSSPS, 2011).

Transforming Your Care reflects the Bamford Vision, with both committed to delivering the best outcomes, increasing independence, choice and service improvements for people with mental ill health or a learning disability (DHSSPS, 2011). This will enable accelerated service enhancement in line with the needs and expectations of service users and carers in a co-ordinated and consistent manner[2] (DHSSPS, 2012b, p. 7).

This is matched by the following comments in *Transforming Your Care*: 'The Review heard nothing which challenged Bamford but did hear frustration at the speed of implementation.' (DHSSPS, 2011, p. 89). The reasons for required changes, and the key principles on which the review is based, cohere with the approach and strategic and long-term perspective taken by the Bamford Review. There were several direct references to mental health among the evidence presented in the 'Reasons for Change' section of *Transforming Your Care*. With respect to 'Reason 6 – Sustainability and quality of hospital services':

> "Investment in Mental Health, Learning Disability and Children and Family Services in NI is up to 30% less than in other parts of the UK because our model over consumes resource in hospital provision". (DHSSPS, 2011, p. 28).

With respect to 'Reason 8 – The need to meet the expectations of the people of NI [Northern Ireland]':

> There were positive comments about the existing service, 22.6% of the people interviewed in the omnibus survey, which was undertaken to inform the Review, stated that they were very satisfied with health and social care provision in NI and 54.8% were fairly satisfied. However, the Omnibus survey

[2] Many of the comments and recommendations throughout both *Transforming Your Care* (DHSSPS, 2011), and *Transforming Your Care: Strategic Implementation Plan* (HSCB, 2013), have relevance to users of mental health services and their carers. However, these have not been analysed for their appropriateness and relevance for these particular groups.

> results went on to highlight dissatisfaction with: … the quality of services for people with mental health problems and learning disabilities. …
>
> Access to Mental Health Services: 93% of people (in an online survey that was also undertaken to inform the Review) stated that improvement was required to the availability of mental health services (43% stated that a lot of improvement was required. …
>
> People with a Mental Health problem: 93% (88% online) felt improvement is required including 43% (28% online) who felt that a lot of improvement is required. (DHSSPS, 2011, p. 30)

The 'Future Model' articulated in *Transforming Your Care* outlines clear policy directions for the development of mental health services:

> "There will be a consistent approach to the provision of mental health services through the stepped care model, with most services being provided in the community by community mental health teams and voluntary and community sector partners." (DHSSPS, 2011, p. 46).
>
> "Mental health treatment services will also be available at home, provided by Crisis Response and Home Treatment teams. This will result in reductions in inpatient care". (DHSSPS, 2011, p. 46).
>
> "An urgent care model will be implemented in every area to provide 24/7 access to urgent care services. These services will be planned in accordance with local need. Whilst the model will take account of local circumstances, the outcomes will be consistent. The system of urgent care will ensure each community has local access to urgent health and social care services, variously provided by GPs, urgent care specialist nurses, mental health crisis response teams and emergency social workers." (DHSSPS, 2011, p. 47).

In terms of overall funding required, *Transforming Your Care* states that:

> "…it is estimated that transitional funding of approximately £25 million in the first year; £25 million in the second year; and £20 million in the third year will

be required to enable the new model of service to be implemented." (DHSSPS, 2011, p. 126).

However, it provides no breakdown of how this should be allocated to the implementation of particular recommendations or sets of recommendations with respect to particular services.

Transforming Your Care does note the reality of higher levels of need for such services in Northern Ireland and their connection to the legacy of the conflict:

> "Northern Ireland has higher mental health needs than other parts of the United Kingdom. Based on the Northern Ireland Health and Social Wellbeing Survey (2001), 24% of women and 17% of men in Northern Ireland have a mental health problem – over 20% higher than the rates in England or Scotland." (DHSSPS, 2011, pp. 89-93).

> "Factors contributing to these rates include persistent levels of deprivation in some communities in Northern Ireland and the legacy of Northern Ireland's troubled history. For example, a recent study of the families of victims of Bloody Sunday found persistent effects of these traumatic events on the individuals concerned, with evidence of psychological distress still being found more than 30 years after the event." (DHSSPS, 2011, pp. 89-93).

> "The incidence of suicide in Northern Ireland has been a particular concern in recent years. Suicide rates increased by 64% between 1999 and 2008, mostly as a result of the rise in suicides among young men. In 2008, 77% of all suicides were males and 72% were 15-34." (DHSSPS, 2011, p. 89).

4.11 Transforming Your Care Strategic Implementation Plan – October 2013

The *Transforming Your Care: Strategic Implementation Plan* (hereafter referred to as *Implementation Plan*) provides little in the way of additional detail on mental health policy, focusing in the main on high level policy outcomes (Health & Social

Care Board (HSCB), 2013). As major initiatives and drivers of the transformation with respect to mental health, it envisages:

- developing child and adolescent mental health services;
- six admissions units, one in each of the five local areas plus one more unit in the Western area;
- significant reduction in institutional care and the number of inpatient beds across the region by 2015; and
- improved focus on community based treatment. (HSCB, 2013, p. 6)

One of the 'Key Proposals' identified in the *Implementation Plan* is: 'Confirming the closure of long stay institutions in learning disability and mental health with more impetus into developing community services for these groups.' (HSCB, 2013, p. 14). The document also identifies the following 'key commitments' within the mental health programme of care.

- Mental health services will focus on their community teams' interface with primary and secondary care. The importance of 'joined up' working was emphasised repeatedly in consultation responses relating to mental health services and all HSC organisations will continue to promote effective working between community services that are provided to people with mental health problems. The services will also explore the use of technology to aid mobile working and create a stronger network with primary and secondary care, enhancing home treatment models.
- Across the region, there will be a focus on resettling those people in the community who are living in long stay hospitals. This will involve close working with voluntary sector providers.
- Mental health services will ensure that no patient is required to live in a hospital after their treatment has been completed. Therefore mental health services providers will ensure the resettlement process for all people currently living in mental health hospitals has been completed by March 2015.
- As part of this community work, the teams will also seek to form closer working ties with the voluntary sector to integrate where possible, their

resources into the transformation initiatives and send service users to the most appropriate care provider.

- In continuing to focus on personalised care of service users, increasing the uptake of self-directed and individual budgets can be achieved with the involvement and support of carers.
- Carers play a well-established and critical part in the overall care and wellbeing of people with mental health needs. There will be continued and committed support for carers ensuring they have access to community-based interventions which enhance their quality of life, for example employability and emotional wellbeing.
- Regionally there will be a reduction in the number of acute mental health inpatient beds over the next 3 to 5 years to a point on 31st March 2015 where:

    - No patient will be living in a long stay mental health hospital setting.
    - 6 in-patient acute mental health units for those aged 18+ are to be developed. There would be one site in the Northern, Southern, South Eastern and Belfast areas, with two in the Western area. In order to reduce stigma and ensure there is good access to acute care, it is necessary to locate mental health hospitals close to acute hospital provision, recognising that this may not be possible in all circumstances.

    – Following the range of views expressed during the public consultation on the proposals for the location of the in-patient acute mental health units in the Western area, further consideration is to be given to this matter through the completion of a Business Case looking at a range of options. This will be completed before a final decision is made by the Minister on where the second unit will be located.
- Regionally the CAMHS service will focus on developing its service. It will implement the Regulation and Quality Improvement Authority (RQIA) recommendations in relation to CAMHS. This will involve cross boundary cooperation.

- LCGs [Local Commissioning Groups] will continue to tackle suicide through implementation of the Refreshed Protect Life Strategy 2012
- The transformation of mental health care will be progressed through the implementation of the stepped care model, the Mental Health Services Framework, Regional Psychological Therapy Strategy and related NICE [National Institute for Health and Care Excellence] Guidance. These have been designed to enable the reorganisation of services across the primary, community, and secondary care systems by matching service intervention with a person's presenting needs. Integral to the model is the emphasis on prevention, early intervention and the development of integrated care pathways which will simplify and promote better access to care across each LCG locality.
- Improving access to psychological therapy is a fundamental component of recovery and is critical to the successful implementation of the Stepped Care Model for people with common mental health problems. It is within this context that each LCG locality will establish a dedicated Primary Care Psychological Therapy Service with the capacity to provide through a single gateway, facilitated self-help, group therapy, and/or one-to-one counselling or Cognitive Behavioural Therapy for common mental health problems.
- Substance misuse services will implement existing Health Improvement strategies which aim to increase population awareness of alcohol/substance misuse related harm in partnership with community and voluntary sector. LCG Localities will support the implementation of the regional Integrated Care Pathway for substance misuse and ensure practice reflects such care across steps 3 and 4. This will also involve working with primary care and other community based services to undertake agreed 'screening and brief intervention' programmes.
- Advocacy services' standards will be improved in line with the 2012 Guidance for Commissioners. Services will be in place to provide support for women with serious psychiatric conditions in pregnancy and the post-partum period (HSCB, 2013, pp. 38-39).

Further relevant key commitments are articulated within 'Family and child care'

- Develop Child and Adolescent Mental Health Services: reduce the number of children waiting for service and a reduction in waiting times.
- Increase availability of emergency CAMHS cover to avoid acute admissions.
- Child and Adolescent Mental Health services will continue to implement the recommendations outlined in the RQIA CAMHS review (February 2011) and the DHSSPS Policy Guidance 'Child and Adolescent Mental Health Services: A Service Model' (July 2012). This guidance provides a basis for reshaping service provision and will require each LCG locality to establish a Primary Mental Health Team and Crisis Resolution and Intensive Treatment Teams as part of CAMHS service provision. Trusts will also be required to take steps that further integrate CAMHS, Child Development and Behavioural Services into a more coherent system of care (HSCB, 2013, p. 42).

4.12 Mental health and the issue of resources: Current context

The vision for mental health services of the Bamford Review (2005), the high level political commitments of the Northern Ireland *Programme for Government* (Northern Ireland Executive, 2012b), and the agenda for reform of health and social care provision in Northern Ireland of *Transforming Your Care* (DHSSPS, 2011) have created a complex policy nexus for mental health in Northern Ireland. In considering issues of the resources allocated to the delivery of these policy agendas, the complex matrix of need, unmet need, and delivery of services are added factors. Measuring a lack of 'parity of esteem' between mental and physical health with respect to indicators such as excess mortality, the burden of disease, and the 'treatment gap' further complicates any attempt to assess the overall 'adequacy' of funding for mental health services (Houses of Parliament Parliamentary Office of Science and Technology, 2015).

Measuring the amount and impact of expenditure on 'mental health' and its trajectory over time is not a simple task. At any given moment, resources will have been spent by a range of government departments in Northern Ireland and across a range of programmes of care through DHSSPS to both statutory and voluntary sector organisations. For example, in March 2012, the DSD (Department for Social

Development) Supporting People Programme provided 107 accommodation-based services (providing 1,064 units of accommodation), at a combined contract value of £9.87 million. In addition, there were 10 'floating support' schemes of a combined contract value of £622 k. The 2012/13 budget for existing services was £10.49 million (Northern Ireland Housing Executive, 2012, p. 31). Support for people with mental health issues represents 7.5% of contracted Supporting People units and 16.8% of the Supporting People budget (Northern Ireland Housing Executive, 2012, p. 31).

There are a number of funding sources apart from DHSSPS, such as the European Social Fund or government employment programmes managed by the Department of Employment and Learning (DEL), to support people with mental health issues into employment. These provide a variety of impacts but are not considered here. The largest amount of mental health expenditure comes through DHSSPS and that Department is therefore the focus of this section.

When seeking to compare levels of spend over time, there are additional complexities. Increased money allocated must be assessed in the changing contexts of demographics, real need, and real value of money spent given varying rates of inflation. Any policy analysis of funding for mental health services in Northern Ireland is thus necessarily limited by the constraints outlined above.

Securing a sustainable budget for health and social care in Northern Ireland has been a matter of increasing political contention and it has been high on the political agenda and in its media profile. Whilst there is a strong economic case for investment in mental health services (Centre for Economic Performance, 2012; Knapp et al., 2011), this case has not been fully accepted as reflected in actual health spending decision-making in Northern Ireland. In the current climate for public finances, it is difficult to envisage how such investment might actually be secured in budgetary or political terms.

4.13 Historical Spend on Mental Health in Northern Ireland

The DHSSPS provided this project with information about mental health expenditure in Northern Ireland obtained from the HSC Board. The figures for mental health expenditure have been taken from **T**rust **F**inancial **R**eturn (TFR) reports. These reports capture Trust expenditure for the current year, but there are some points that should be kept in mind when reviewing this information and analysing its significance.

The TFR report does not take account of the full expenditure on health and social care. There is also expenditure incurred by the HSCB or Public Health Agency (PHA) on the provision of services other than by each Trust in Northern Ireland, for example:

- **E**xtra **c**ontractual **r**eferral (ECR) expenditure for patients referred to services in Great Britain and the Republic of Ireland (mental health services are represented in such arrangements); and
- PHA and HSCB expenditure on grants to voluntary sector organisations (including Lifeline, Protect Life, health promotion and other mental health specific activities).

It is also important to note that the TFR totals may fail to capture the full picture or may capture expenditure in a potentially misleading way. The TFR only captures the in-year impact of funding for services; the full year effect on total annual expenditure of new services may not be captured if services are implemented part way through the year. Furthermore, the TFR captures non-recurrent funding that may have been given in-year to address pressures in a Trust (e.g. 'winter pressure' or 'waiting list' funding initiatives). These are less likely to be in mental health services than some other programmes of care, but might affect comparisons with other programmes of care.

Trusts complete the TFR returns on a fully costed methodology that incorporates fixed, variable, and overhead costs. Within mental health services, people have been resettled from long-stay mental health hospital wards to community facilities. The older hospital buildings that provided care services have, in the past, attracted a

larger proportion of corporate overheads (e.g. costs of central administrative departments such as human resources, finance, chief executive's office, corporate services etc.). However, as these buildings are becoming vacant with ward closures, the share of corporate overheads that was assigned to these buildings is being reassigned to other services and other programmes of care, and may no longer be within the expenditure of the mental health programme of care. A reduction in expenditure may therefore be consequent on this shift in overhead allocation but this, in reality, does not mean a reduction in expenditure on actual delivery of services. If overheads in the voluntary sector were to be lower than in the statutory sector, then a shift of services to the voluntary sector might also produce a similar effect on the headline figures for overall expenditure.

There was a real terms increase in mental health expenditure from £221.15 million in 2007/08 to £233.78 million in 2013/14 (see Table 4.1). The pattern of expenditure over this period was not one of steady increase; there was a significant increase in 2008/09 and then steady, albeit marginal, decreases thereafter until 2013/14. From 2007/08 to 2013/14 there was an overall increase of 5.7% in expenditure on mental health by the Trusts. The per capita spend by Trusts on mental health also increased significantly in 2008/09 and then experienced marginal decreases. Overall per capita spend by Trusts was 1.8% higher in 2013/14 than it was in 2007/08.

The share of overall health expenditure received by mental health did not change significantly between 2004/05 (8.0%) and 2009/10 (8.2%), although it did dip as low as 7.3% in 2007/08. (QUB Budget Analysis Project, 2013). In contrast with an earlier figure for 2002/03, this shows a decline of 9.3% of total spend:

> 'This is significantly lower than the corresponding figure of 11.8 per cent in England. To match the English share, spending on mental health services in Northern Ireland would need to rise by £60.2 million, an increase of 26.3 per cent' (Northern Ireland Association for Mental Health, 2004, p. 9)

Table 4.1. Expenditure of HSC Trusts on Mental Health: Key Statistics (2013/2014 Pay and Price Levels)[3]

	2007/ 08	2008/ 09	2009/ 10	2010/ 11	2011/ 12	2012/ 13	2013/ 14
Mental health expenditure (£m)	221.15	243.60	240.72	238.58	235.54	233.79	233.78
Annual increase (%)	-	10.2%	-1.2%	-0.9%	-1.3%	-0.7%	0.0%
Per capita (£)	125.53	136.92	134.23	132.19	129.82	128.20	127.77
Per capita annual increase (%)	-	9.1%	-2.0%	-1.5%	-1.8%	-1.3%	-0.3%

The 'McKinsey Report' documents a stark contrast in terms of spending on mental health and learning disability compared to England:

> When our region's higher levels of deprivation and social need are taken into account, Northern Ireland's health and social care system spends 7-16% less than England on health and social care – equivalent to between ~£250 million and ~£600 million in 2009/10. In particular we spend less than half of England's per capita spend on supporting people with mental health problems and learning disabilities (DHSSPS, 2010, p. 14).

Internationally, it is recognised that whilst mental health spending has generally been rising, there are particular challenges that mean this is not necessarily sufficient in the current global economic context. In OECD countries[4] mental health spending is:

> between 5% and 18% of total health expenditure (in countries that are able to break down total spending). But treating unmet need remains a significant issue. It could even be argued that spending on mental health is too low, given

[3] Information provided by DHSSPS.

[4] The Organisation for Economic Cooperation and Development (OECD) has 34 member countries from across the world. See http://www.oecd.org/

> its large overall economic and social burden. For example, mental illness is responsible for 23% of England's total burden of disease, but receives 13% of the National Health Service health expenditure…
>
> The current economic crisis affecting many OECD nations makes effective mental health policy even more urgent. Several countries have imposed austerity measures in health and welfare, at a time when the economic crisis is likely to negatively affect mental health in the form of insecurity, anxiety and depression. Bleak economic conditions make the need to invest wisely in mental health, and to make good resource allocation choices, all the more pertinent. (OECD, 2014, p. 2).

The percentage of overall health expenditure on mental health in Northern Ireland in 2009/10 of 8.2% is clearly towards the lower end of the international range identified by the OECD.

Section 3 of the *Action Plan 2011-2015* (DHSSPS, 2012b), under the heading 'Challenges ahead', comments on issues of finance (paragraphs 3.3 to 3.14), including proposed and actual additional funding for mental health as laid out in Table 4.2. Specifically, the *Action Plan* comments that 'the widespread constraints in public spending in 2010/11 impacted on the amounts planned for mental health' and that the amount allocated to mental health was reduced from the proposed £27 million to an actual sum of £17.1 million (DHSSPS, 2012b, p. 11).

It is clear from Table 4.2 that over the period from 2008/09 to 2013/14 there was a variation in the actual additional funding for mental health each year between £1.9 million and £12.40 million. In 2010/11 there was significantly less spend than had been proposed. In other years the proposed additional spend was either delivered or delivered with a marginal shortfall. The proposed and achieved additional spend in recent years has increased again, but has not reached the additional investment of over £12 million, which was proposed in 2008/09 and 2010/11. This significantly greater additional investment in mental health was almost achieved in 2008/09, coming in the period following the completion of the Bamford Review in 2007. It was not achieved in 2010/11 where the shortfall compared to the proposal was £9.60 million. In 2012/13 (£6.5 million) and 2013/14 (£5 million), what were perhaps more

realistic targets for additional spend were set and met in terms of actual spend. Overall, since 2008/09 there has been actual additional funding for mental health in every year through to 2013/14 with a total amount of additional funding over this period of £28.6 million. However, this is £9.9 million less than had been proposed over the period. There has been significant increase in expenditure on mental health, but not as significant an increase as had been intended.

Table 4.2. DHSSPS Proposed and Actual Additional Funding for Mental Health 2008/09 to 2013/14[5]

	2008/09 (£m)	2009/10 (£m)	2010/11 (£m)	2012/13 (£m)	2013/14 (£m)	TOTAL 2008/09 - 2013/14 (£m)
Proposed spend	12.75	1.85	12.40	6.5	5.0	38.5
Actual spend	12.40	1.90	2.80	6.5	5.0	28.6
Difference	0.35 less	0.05 more	9.60 less	0	0	9.90 less

M: million.

The figures in the Table 4.3 show that actual spend on mental health services increased over this period. The 19.5% increase in spend does not take account of the impact of inflation. By way of comparison over a different period, actual expenditure on mental health rose by 30.3% between 2004/05 and 2009/10 as documented in a Northern Ireland Assembly Research Report (Pidgeon, 2011). Pidgeon's Report shows that the increase in mental health expenditure was smaller than the increase in

[5] The figures for 2008/09 to 2010/11 were taken from DHSSPS, 2012b, p. 12. The DHSSPS has helpfully provided this project with an update to the table to cover through to 2013/14. However, the project has been advised the figures are not necessarily reflective of the full picture of mental health spend.

all other programmes of care[6] with the exception of Elderly Care (27.4%). The increase in mental health expenditure was also less than the percentage increase in total expenditure (41.9%).

It is evident that resources have shifted from spend on hospital care to community care. In keeping with the Bamford Review's call for a move to 60% spend on community services[7], there has been a significant movement in that direction with a drop in the proportion of total hospital spend from 49.0% to 44.6%. In Northern Ireland in 2011/12 mental health hospital spend was about 45% of total mental health expenditure. By way of comparison[8], in England in 2011 mental hospital expenditures were 30.92% of the total mental health budget. In Iceland in 2011 mental health hospital expenditures were 53.05% of the total mental health budget. In Japan, mental health hospital expenditures were 76.12% of the total mental health budget. It is difficult to draw any substantive conclusion from such comparison and the differences in proportion of spend could be explained by a number of factors, including an overall under resourcing of mental health services. For example, in Japan mental health expenditures by the government health department/ministry is 4.94% of the total health budget. Hospital expenditure could thus be high as a proportion of total spend because only relatively acute mental health care is provided.

[6] These range from a 136.2% increase for Primary Health and Adult Community, to a 47.8% increase on acute services, and a 37.8% increase on Physical and Sensory Disability.

[7] Bamford Review (2005, p. 45) 'The present balance of resource spend is approximately 60% on hospital services and 40% on community services. The recommended developments in community services should be reflected in a reversal of this balance of expenditure within 10 years of implementation of the Strategic Framework'.

[8] World Health Organisation, Mental Health Atlas 2011. Available at: http://www.who.int/mental_health/evidence/atlas/profiles/en/#U

Table 4.3. Mental Health Expenditure 2007/08 to 2013/14[9]

	2007/08 (£m)	2008 09 (£m)	2009/10 (£m)	2010/11 (£m)	2011/12 (£m)	2012/13 (£m)	2013/14 (£m)
Hospital	95.81 (49.0%)	109.49 (49.4%)	107.04 (47.7%)	103.46 (45.4%)	101.90 (44.8%)	104.75 (45.6%)	104.18 (44.6%)
Community and social services	99.88 (51.0%)	111.96 (50.6%)	117.26 (52.3%)	124.54 (54.6%)	125.55 (55.2%)	125.10 (54.4%)	129.60 (55.4%)
Total actual spend	195.69 (100%)	221.45 (100%)	224.30 (100%)	228.00 (100%)	227.45 (100%)	229.85 (100%)	233.78 (100%)

[9] This table has been updated with data for 2011/12, 2012/13 and 2013/14, provided by DHSSPS.

4.14 Financial Challenges Facing DHSSPS in 2014/15

In considering the additional expenditure needed to deliver the Bamford Vision and the *Transforming Your Care* reform agenda, the essential context is that DHSSPS is facing considerable financial difficulties in terms of meeting existing commitments. A *Briefing Paper for Health Committee* (2014)[10] presents a striking overview of the recent financial position of the DHSSPS:

1. The scale of the financial challenge facing DHSSPS in 2014/15 can be summarised as follows:
    - DHSSPS requires additional funding of **£420 million** in order to meet all identified costs of existing policies and expectations.
    - However, the Executive's planned increase to the DHSSPS budget amounts to **£90 million.**
    - In addition to this, savings of **£170 million** have been identified by DHSSPS.
    - Which means that **a funding gap of £160 million still needs to be resolved.**

Table 4.4, which is drawn from the *Briefing Paper:*

> sets out the DHSSPS allocation across the current budget period'. The table highlights that whilst the Department's allocation increases each year over the Budget period, these uplifts have to fund inflationary cost pressures, demography pressures from an increasing and ageing population and the cost pressures associated with new treatments and patient expectations (DHSSPS, 2014, http://www.dhsspsni.gov.uk/index/statements-minister/statements-minister-2014/fo2014-15.htm).

The Briefing Paper explicitly identified continuing mental health resettlements as a key pressure in 2014/15.

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[10] Department of Health, Social Services and Public Safety 'Briefing Paper for Health Committee DHSSPS Financial Position in 2014/15'. Available at: http://www.dhsspsni.gov.uk/index/statements-minister/statements-minister-2014/fo2014-15.htm

Table 4.4. 'Budget 2011 - 2015 Settlement'

	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Current expenditure	4,838.1	4,447.6	4,569.2	4,659.4
% Uplift	-	1.5%	2.7%	2.0%
Real terms % (updated at April 2014)	-	-0.3%	0.9%	-0.2%

Taken from: Department of Health, Social Services and Public Safety (2014) *Briefing Paper for Health Committee DHSSPS Financial Position in 2014/15*. Available at: http://www.dhsspsni.gov.uk/index/statements-minister/statements-minister-2014/fo2014-15.htm

4.15 DHSSPS Consultation on Draft Budget – November 2014

As part of the process of development of the Northern Ireland Executive Budget, the DHSSPS consulted on a Draft Budget 2015/16 (DHSSPS, 2014b). This was an assessment of the implications of the Executive Draft Budget (which was consulted on separately) for potential impact on DHSSPS service delivery, patients, and clients (see DHSSPS, 2014b). The DHSSPS Draft Budget identified potential savings and cost reductions of £164 million, but was clear that this 'does not allow for the funding of new service developments in 2015/16', which were estimated to cost £110 million (DHSSPS, 2014b, p. 12). Mental health and *Transforming Your Care* transitional funding were expressly identified as an area of pressure with respect to new service developments (see DHSSPS, 2011; HSCB, 2013). It was the assessment of the DHSSPS that 'the £110m [million] of service developments are unaffordable under the current draft Budget scenario and that the Executive would need to identify additional funding as part of the final Budget to enable them to be taken forward' (DHSSPS, 2014b, p. 12).

In terms of DHSSPS capital requirements (given work that is already contractually committed, high priority projects, new projects and recurrent expenditure), the DHSSPS considered there to be a considerable shortfall. For DHSSPS, the proposed 2015-16 capital budget represented an overall shortfall of £50 million. (DHSSPS, 2014b, pp. 13-14). This shortfall would mean that a number of high priority projects

not yet contractually committed would be delayed by three to six months and no new projects planned to commence in 2015/16 could proceed. The DHSSPS (2014b) Draft Budget 2015/16 Consultation explicitly claimed that this would have a negative impact on the delivery of the following.

- The Belfast City Hospital Mental Health Inpatient unit.
- The South Eastern Health and Social Care Trust (SEHSCT) new Mental Health Unit.
- Western area second Mental Health Unit.

4.16 Northern Ireland Executive Budget 2015-2016: Implications for Service Development

In the absence of a formal Programme for Government that would cover the 2015-16 financial year, the Northern Ireland Executive agreed that the final budget for 2015-2016 would be predicated on a carry forward of the five key priorities outlined in *The Programme for Government 2011-2015*. In the Budget 2015-16, 'these priorities have influenced the Executive's key plans for 2015-16 and guided the final departmental outcomes' (Northern Ireland Executive, 2015, p. 34). Thus, there is a continuity of policy positions carried forward, which are now to be delivered in the new budgetary situation. The Budget 2015-2016 does not protect the funding of any specific department(s), but does provide some protection for front-line health services.

> For health this has been derived by exempting front-line health and social care from the baseline reductions facing other departments. Additional allocations of £204 million were also provided, resulting in a Final Budget outcome for Department of Health, Social Services and Public Safety which is some 3.4 per cent higher than the baseline position (Northern Ireland Executive, 2015, p. 37).

It is important to note that this 3.4% increase might well be offset by a net increase in population or an increase in the real need for front-line health services (e.g. by an aging population), or both. Thus, in terms of spend, which is at the discretion of the DHSSP (non-ring-fenced resource DEL (Departmental Expenditure Limits)), there

has been an increase of 3.4% from £4,542.7 million to £4,697.9 million (Northern Ireland Executive, 2015, p. 37). This increase for DHSSPS is in the overall context of a decrease in the non-ring-fenced DEL of 1.4% coming to Northern Ireland from HM (Her Majesty's) Treasury (Northern Ireland Executive, 2015, p. 25). Forty-six per cent of Northern Ireland's non-ring-fenced resource DEL budget goes to DHSSPS (Northern Ireland Executive, 2015, p. 41).

In terms of the individual Departmental budget outcome for DHSSPS, it is stated that: 'The scale of the financial challenge facing the Department and the HSC in 2015-16 is both significant and unprecedented.' (Northern Ireland Executive, 2015, p. 96). It is abundantly clear that the resources needed for implementing the Bamford Vision, and a *Transforming Your Care* change process in keeping with it, are not forthcoming in the 2015/16 period insofar as these require new service developments. Nonetheless, the Budget 2015-16 states that there will be 'a focus on making progress on key reforms, including those being taken forward under TYC [*Transforming Your Care*]', but only 'within the resources available' (Northern Ireland Executive, 2015, p. 96). There is explicit recognition of a radically changed financial situation for health and social care in Northern Ireland, yet this is not matched by a re-evaluation of the resources available to bring about change nor of how those resources might now be secured.

The breakdown of spending areas within DHSSPS, which is provided in the Northern Ireland Executive Budget, does not contain specific information with respect to mental health (Northern Ireland Executive, 2015, pp. 100-102). In terms of the impact of the DHSSPS Budget Outcome on service delivery, there are nonetheless explicit commitments to continue certain key areas of work in relation to mental health, including mental health promotion and the Mental Capacity Bill (Northern Ireland Executive, 2015, pp. 94 and 96). In terms of capital spend, the plan is that major projects will be managed within the available budget. (Northern Ireland Executive, 2015, p. 97).

4.17 Conclusion

At a strategic level Transforming Your Care is currently the cornerstone of mental health policy in Northern Ireland, and in the main, its proposals cohere with the recommendations of the Bamford Review in terms of its direction of travel. However there is uncertainty over the future of Bamford monitoring arrangements and this could lead to loss of momentum and focus for change. Although TYC proposes major changes to the health and social care system in Northern Ireland, the process itself is relatively silent on changes to funding necessary to deliver change in an equitable manner which addresses long-term structural issues of resource allocation to mental health services as identified by the Bamford Review.

This review of funding arrangements demonstrates there is a need for greater clarity around the levels of mental health need in Northern Ireland, what levels and kind of expenditure would meet that need, and how progress towards achieving this might be most accurately indicated. In TYC there has been no explicit recognition of historical underfunding of mental health services within overall health and social care funding, yet it was previously claimed by the Minister for Health that "we have a 20% smaller spend pro rata than in England, but a 25% greater need" (Michael McGimpsey, NI Assembly, 3.00pm, 12th October 2010). Over the period 2008-2014 actual spend on mental health by Trusts has been around 25% less than that proposed.

5 Findings

5.1 Analysis of Themes

This section presents an analysis of mental health services under four broad categories: Strengths, limitations and challenges, Troubles-related issues in the Northern Ireland context, and priorities for further development. Within these categories, the report identifies key themes arising from the evaluation based on all of the data gathered from respondents. Each key theme is presented with quotes that are linked to and support the theme identified. The aim was to identify the main issues that different stakeholder groups felt were significant in current service provision and to highlight key priorities for improving services.

5.2 Strengths of Mental Health Services in Northern Ireland

Individual interviews and focus groups meetings with stakeholders generated a wide range of responses in relation to the question about the strengths of mental health service provision.

5.2.1 Further Development of Care in the Community

There was a clear consensus from the consultation with commissioners that the most significant development during the past decade had been the move away from long-stay care in hospitals to a mental health service that was primarily based on care in the community. It was acknowledged that the development of community services had required significant financial investment but had resulted in major benefits for service users. As a result of this investment, commissioners felt there had been a change in public perceptions about the type of care and support now expected from mental health services:

> "People no longer live in mental health hospitals … that practice has ended. There is an expectation that people will get the assessment, treatment, support they require in the community" (mental health commissioner).

Mental health professionals also identified the move away from hospital care among the main strengths of the current system:

> "We're moving away from the asylum model of care further and further and that can only be a good thing" (mental health professional, statutory sector).

It was acknowledged that the Bamford Review had been the primary catalyst in driving the extensive change process in mental health services and it was generally felt that much had been achieved as a result of this process:

> "If we held ourselves up against the Bamford Action Plan I think we have done quite a number of things we have said we would do … Resettlement is a good example of that, significant investment in severe and enduring mental illness … service user engagement" (mental health commissioner).

In contrast to the detrimental impact of long-term hospital care, both commissioners and professionals highlighted the positive benefits for service users that had resulted from the development of community-based services:

> "The longer-term care patients have now all been moved to supported housing in the community – the tenants have really blossomed in terms of their independence, self-esteem, and self-efficacy" (mental health commissioner).

> "Part of the difficulty ten years ago was that patients were kept in … whereas they are more inclined to use home treatment … get on in the real world" (mental health professional, statutory sector).

Many service users also presented a positive view of their experience of current mental health services in the community and contrasted this with their past experience of institutional care:

> "Before, you were just doped with medication, sent away, locked away, you were too much trouble" (service user).

5.2.2 Professional Qualities and the Importance of Relationships

Service users and carers highly valued the quality of inter-personal relationships with professional staff involved in their care. Having professionals who listened to them was identified by service users as among the most important strengths of the care and support they received. The following comment was typical:

> "Being listened too, if you get the right person to listen, rather than just giving tablets" (service user).

Carers also highlighted the demonstration of person-centred qualities by professionals, including taking time to listen, to show empathy, to essentially recognise the role of carers and the fact they often lived with the family member on a continuing basis, as necessary and validating in making a fundamental difference to their lives:

> "… an understanding that the carer knows the person. That's the person who is spending time with their loved one … to me, that is the difference between things breaking down and stuff being prevented" (carer).

> "Talking, it is always a good thing to have somewhere to go and feel "normal" (carer).

Having opportunities to engage with their peers in support groups and through other activities were invaluable to service workers, as was the support of family and friends:

> "In my experience, the treatment I have received comes from what I have observed of others in self-help groups and friends/family" (service user).

5.2.3 Range and Quality of Community-Based Services

Feedback from all stakeholder groups highlighted the range and quality of community-based provision, including therapeutic services (when available) as a significant strength of mental health provision in Northern Ireland. For example, one service user made the following comment:

> "I took part in cognitive behaviour therapy alongside some exercise and diet work as part of a course … in 'X area'. This 'one-on-one' approach really allowed me to fully explore my negative feelings and behaviours, and the dedicated support meant even when I got overwhelmed I never felt like I was lost, I never felt like giving up" (service user).

Similarly, commissioners identified that one of the main strengths of the current system of mental health provision was the greater range of statutory sector, specialist community-based services now available to meet a range of diverse needs:

> "Now we have many different types of community mental health teams … crisis response, home treatment teams, rehabilitation teams, eating disorders, services for people with personality disorders, and forensic services" (mental health commissioner).

Several carers highlighted the importance of home visits from professionals as it enabled them to see the family member in their 'lived situation', appreciate the constraints and challenges facing the carers, and apprehend the contextual factors impinging on the situation. For carers, home visits indicated that the professional was willing to go the extra mile, to be proactive and person-centred. An added benefit of home visits was that it avoided the stress and associated memories of going to the hospital. One carer was clearly very grateful for the professional's willingness to see her and her son in their home environment:

> "And he would do home visits, which I thought was great, particularly when 'A' was really unwell. Mr 'B' was great and he used to understand. And he would say to me, the stress that you and your husband are under to get him to go to the hospital, I will come out to the house. And he used to come out to the house, like once a fortnight" (carer).

5.2.4 Service User and Carer Involvement

The development of service user and carer involvement at all levels was universally viewed by mental health commissioners as one of the most significant achievements in the development of mental health services during the past decade:

> "We are moving much more towards the 'no decision about me without me approach' … That has allowed us to radically re-shape the provision of mental health care … the service user has been at the core of that" (mental health commissioner).

Commissioners highlighted that particular progress had been made in developing service user involvement in the planning and commissioning of services. One commissioner, for example, commenting on the impact and positive contribution of service users and carers to the Trust's senior management group, observed that this engagement had not been without its challenges for professional staff:

> "It has led to some significant changes that have been led by service users and carers that we may not necessarily have taken forward as a priority … it has changed how we do business and how we conduct business … we think more carefully about the language we use … the NHS mental health speak that is quite a secretive language to mental health professionals" (mental health commissioner).

Feedback from service users generally indicated that they felt they now 'had a voice' within the wider system, attributing this, in large part, to the support of professional key worker staff. Professional staff also highlighted that the active involvement of service users as peer advocates had been a major development in the mental health care system:

> "One of the big successes is the use of patient advocates … that's been fantastic … works really well" (mental health professional, statutory sector).

Service users were also very positive about peer support from others who had experienced what they had experienced and therefore could empathise accurately and induce a sense of not being alone:

> "You can bounce off people in here. You can learn how to cope from others" (service user).

> "I found CBT [cognitive behavioural therapy] didn't do me any good … I found talking to other people … bouncing off each other good" (service user).

5.2.5 Development of a Recovery Approach

Both mental health commissioners and professional staff felt significant progress had been made towards developing a recovery-based orientation in mental health services. Commissioners identified the importance of the ImROC process and highlighted positive developments resulting from this initiative that had taken place in both statutory and voluntary sector organisations. Whilst the development of Recovery Colleges was also viewed as a catalyst for change, it was felt that funding for these developments needed to be provided on a more permanent basis:

> "There's new thinking, people talk now more about recovery rather than just treatment … the language is different and that kind of training has been made available" (mental health professional, voluntary sector).

> "The infrastructure that each [HSC] Trust has been able to put around that recovery ethos that ImROC process has been entirely at the [HSC] Trust's own cost … its sustainability and longevity needs to be supported by a more permanent funding strategy" (mental health commissioner).

A number of respondents acknowledged there were different perspectives on what constituted a recovery approach and conceded further developmental work was required to ensure this orientation was firmly embedded in working practices:

> "There is a tension between what might be the service user view of what a recovery focused service would be and a lot of professionals' views … you don't change culture overnight" (mental health commissioner).

5.2.6 Contribution of Voluntary and Community Sectors

A range of stakeholders recognised the contribution of the voluntary and community sectors to mental health provision and the key role they had played in progressing service developments, including therapeutic services:

> "Positive trend at the moment is the increase in availability of therapeutic type services that are community-based, delivered through the voluntary sector, and more accessible to people who are not necessarily in the care of a psychiatrist … accessed directly" (mental health professional, voluntary sector).

Service users were generally positive about the value and quality of the service they received from voluntary sector organisations. For example, the majority of service users from one voluntary sector organisation felt their attendance at a day care facility was a crucial factor in supporting them in times of difficulty, maintaining good mental health, and preventing an escalation of symptoms.

> "the service has been the best that I have been able to access in 15 years because it is the one place where I am a person and am valued" (service user).

> "The staff are understanding. It is different to someone reading from a text book. They are not judging you, you know what I mean? They treat you like a human" (service user).

A number of mental health professionals within the voluntary sector felt they were often in a more advantageous position to address individual needs through the implementation of innovative and creative approaches:

> "Various mental health charities throughout Northern Ireland are providing a creative and innovative approach to supporting individuals affected by mental ill health in promoting recovery and providing training to health care professionals and members of the community" (mental health professional, voluntary sector).

Commissioning stakeholders also highlighted the positive contribution of voluntary and community sector organisations in addressing unmet needs and developing a

range of innovative services in the areas of, for example, supported living, day care, peripatetic, and domiciliary support.

> "I think the voluntary sector are ahead of us … their user-led services are much stronger … Voluntary organisations are very fleet of foot and can turn a very significant difficulty with a gap in services or maybe unmet need" (mental health commissioner).

Service users provided very positive feedback about the work of the voluntary sector in promoting their recovery and often highlighted their experience of day care, which afforded much needed structure, security, and daily routine that helped them to manage inner anxiety. This form of support helped to give purpose and direction, take away from boredom, and assist in the recovery process. Structure helped to move one out of introspection and thus ameliorated depression. Security came from the realisation that the support offered was not time-limited, that one would not be cut off and returned to a bereft state of isolation, loneliness, and boredom. In this context, the value of an 'open-ended service' cannot be overstated. The following statements are emblematic of this theme:

> "The main thing is that it is a safe haven for us" (service user).

> "It's a structure to your day, every day" (service user).

Interestingly, service users indicated that the type of structure and routine could be informal and prosaic. Creative activities, such as painting, were uniformly welcomed. Referring to their experiences in supported living accommodation, one respondent indicated that:

> "We went to the towpath in summer, and it was really good. It just lifted the illness off me ... I mean the guy who is the key worker and the co-key worker, they take me out shopping and go for a chat and go for a coffee, which is really, really good" (service user).

5.2.7 Human Resources

Mental health commissioners were unanimous that the knowledge, expertise, and commitment of professional staff were among the most important strengths and assets of the mental health system. The following comments were typical of the views expressed about the dedication and quality of professional staff:

> "I think we have got some fantastic staff who make a real difference … people who really care" (mental health commissioner).

Many service users reported they had experienced timely and appropriate interventions and felt that the professionalism and dedication of professional staff were a positive feature of the mental health system in both the voluntary and statutory sectors. A number of service users commented very positively on the person-centred care they had received from hospital staff. For example, one service user was emphatically positive about their admission to an acute mental health ward:

> "They were very kind to me … I had a pretty bad breakdown. They were always there for me, you know … there were some guys in there that went the extra mile for you" (service user).

In spite of reporting difficulties in accessing services at times due to 'long waiting lists', most service users and carers who commented tended to agree that mental health professionals "are of a very high calibre" and are "caring and dedicated." A number of service users particularly highlighted the quality of the support they were receiving from key workers. Typical comments included the following:

> "It is really from my key worker that has stemmed all the positive things about the mental health service" (service user).

A number of service users attending day care services run by one voluntary sector organisation expressed their appreciation for the care and respect demonstrated by professional staff:

> "Instantly all staff members knew my name, staff are wonderful, always willing to listen" (service user).

5.3 Limitations and Challenges Facing Mental Health Services in Northern Ireland

The different stakeholder groups identified a wide range of concerns about the mental health system in Northern Ireland, which were sometimes inter-linked, and collectively tended to outweigh the strengths presented in the previous section.

5.3.1 Financial and Resource Constraints

Mental health commissioners unanimously agreed that the most serious limitation and greatest challenge facing mental health services stemmed from the impact of continuing financial restraint. A number of commissioners reported their organisation was already under serious financial pressure as a result of having to make year-on-year efficiency savings and expressed pessimism about this situation changing for the better in the next few years. Indeed, not only were commissioners worried about securing the continuing financial investment necessary to deliver the Bamford Vision, but several also expressed serious concern about the danger of existing provision being cut back:

> "Worst-case scenario is that we go backwards instead of forwards … if mental health is forced to make more stringent savings then I cannot see how that could be done without significant reduction to existing service provision" (mental health commissioner)

> "This year in particular was very difficult for us and we went through a lot of pain curtailing spend. Indications are that we will have to continue to make savings. I have some very real operational pressures" (mental health commissioner).

5.3.2 Fragmentation of Service Delivery and Communication Breakdown

Respondents from all groups that participated in the evaluation expressed serious concerns about the fragmentation of mental health services in Northern Ireland and the detrimental impact of poor communication between the different parts of the

system on both service users and carers. Feedback from different stakeholders suggested increased fragmentation was connected with developments in the specialisation of community-based mental health provision and reductions in hospital beds, which had taken place since the Bamford Review. A large majority of mental health professionals commented on the increased fragmentation of the mental health system and the resulting impact on service delivery. The following comments were typical:

> "About five years ago, we used to have the CMHT that did all the referrals, they split up into different services, now you have the primary care liaison team, recovery team … Pathways/employment officers…DEL programmes … it's all been diluted" (mental health professional, voluntary sector).

> "Across the board, everywhere … people are saying that person doesn't fit our criteria … Balkanisation of services … doesn't feel part of whole" (mental health professional, statutory sector).

Several commissioners acknowledged that increased specialisation within larger HSC Trusts had presented significant challenges for achieving consistency and a seamless approach to service delivery:

> "Services then become very separate from each other and very much in their silos … there are real challenges bringing those together within bigger [HSC] Trusts and even harder in the rural [HSC] Trusts" (mental health commissioner).

Carers frequently mentioned that problems between interfaces and poor communication between different professionals, specialisms, and facilities had dominated their long experience of the mental health system. The interface between the hospital and community was a central concern in this regard, and rather than holistic, the system was viewed as quite compartmentalised. Carers felt they continually had to fight to receive the appropriate level of services and support for themselves and their loved ones. Carers' concerns and frustrations with the system, and poor communication are illustrated by the following comments:

> "Well they keep them in hospital for far too long because there's nowhere for anyone … especially a young person … to go to … that's another thing, there's no communication between all the agencies … I threw everything up in the air and said, you know what to do? Just let him home and we will look after him" (carer).

> "There is no communication. The carer is completely left out. You are in the lurch … You know, you get these sort of template letters and that's it" (carer).

Both mental health professionals and service users highlighted problems with continuity of professional support and with accessing appropriate follow-up after periods of hospitalisation:

> "Constant changing of appointments … and not seeing the same person" (mental health professional, voluntary sector).

> "There was very little follow-up and no other option provided. It took a long time before I could gain access to other services such as support groups and counselling" (service user).

Mental health commissioners also commented on the challenges of accessing services. They recognised the danger of resources not being used effectively and service users and carers being left feeling their needs were not being met:

> "Different specialist teams … have created unnatural barriers for service users in navigating across the system – it may feel like nobody has really addressed their specific problems to their satisfaction" (mental health commissioner).

Acknowledging that there were issues in ensuring a coherent approach to providing follow-up support after hospital discharge, one commissioner observed that difficulties in navigating through the mental health system were particularly problematic for those service users transitioning between one service and another.

> "Transitions for the service user from one team to another can become a little bit challenging – each team has set up their own service access criteria and sometimes, because of the demand on their service, that criteria can be used to exclude people rather than include them" (mental health commissioner).

A number of stakeholders highlighted that the lack of cohesion between different components of mental health provision was particularly problematic for service users making the transition from CAMHS to adult mental health services:

> "The transition between CAMHS and adults services is a big gap" (mental health professional, voluntary sector).

Service users also highlighted frustrations with the lack of a holistic and personalised approach to mental health care and problems in accessing appropriate hospital care, follow-up, and specialist services:

> "Waiting lists take forever. My GP knows nothing about mental health so keeps referring me back to the psychiatrist, which takes weeks to months. I'm then discharged again and the whole cycle continues. I cannot access anyone except A&E in an emergency, unless it's 9 [a.m.] to 5 [p.m.] weekdays" (service user).

> "The system does not see a person holistically - you do not see the same psychiatrist when you are ill as when you are well, so they don't really know you" (service user).

Several commissioners highlighted tensions in providing sufficient services and support to meet the needs of both service users and carers. It was acknowledged, for example, that together with the detrimental impact on service users, deficits in hospital and community care provision also impacted negatively on carers, particularly in situations where there were less opportunities for respite:

> "One of the biggest challenges is family perceptions – individuals with severe and enduring mental illness don't want to be in hospital, families often want them in hospital – that is a tension for us" (mental health commissioner).

A large majority of mental health professionals also expressed concern that specialist services did not adequately address the needs of those service users with long-term mental health needs: The following comment was typical of the views expressed about limitations arising from the often short-term nature of some specialist services:

> "All 'drop-in' type centres have been taken away and replaced with more structured, time-limited services. These are not suited for those with severe and enduring mental illnesses" (mental health professional, statutory sector).

A number of commissioners identified that fragmentation was also evident at a more strategic level in Northern Ireland given the range of different bodies, including the DHSSPS, HSC Board, five HSC Trusts, the PHA, and the Department of Social Development involved in commissioning different components of mental health services. Together with each of these government bodies it was felt that funding from the Big Lottery and European sources amounted to a highly complex planning and commissioning process. For example, one commissioner characterised commissioning arrangements in Northern Ireland as follows:

> "A fractured arrangement of service delivery and commissioning for such a small population" (mental health commissioner).

Another commissioner highlighted the potential adverse consequences of the system's fractured nature for the commissioning and planning process:

> "Sometimes the left hand does not know what the right hand is doing … it can lead to frustration and confusion from a [HSC] Trust perspective" (mental health commissioner).

However, it was acknowledged that, more recently, the system of mental health commissioning had changed and the climate of financial restraint had encouraged a more 'joined-up' approach:

> "Because of the financial situation – for the first time in my experience - we all sit around the table and say what are the actual priorities in adult mental health" (mental health commissioner).

5.3.3 Limitations and Gaps in Community-Based Services

Together with anxieties about the possibility of future cuts, the majority of respondents from the various stakeholder groups expressed concerns about a range of inadequacies in existing mental health community care services. In addition to

commenting broadly about the general adequacy of services, professionals and service users highlighted a number of specific deficiencies in provision. The following comments sum up succinctly service users' views on overall deficiencies in community-based services:

> "Current mental health services in Northern Ireland are stretched far too thinly for them to be able to provide the level of care that is required" (service user).

> "Long waiting lists … poor levels of communication between professionals … lack of facilities, and long term support" (service user).

Mental health professionals in both the voluntary and statutory sectors frequently expressed concerns about the adequacy of community services. Some professionals in the statutory sector also voiced concerns about the poor physical state of facilities in which they worked:

> "Community mental health teams are stretched to the limit, too little staff and too many demands. Not enough voluntary resources are available, particularly for people with severe and enduring illnesses (mental health professional, voluntary sector).

> "The mental health services in some of the [HSC] Trusts are inadequate in many ways. For example, some of the therapy rooms are unfit for purpose as they are not soundproof, are cold etc." (mental health professional, statutory sector).

Mental health commissioners and professional staff identified a number of specific gaps in community mental health service provision. One of the most common gaps identified related to the need to further improve staff skills and resources in providing psychological services and therapeutic interventions in both community and hospital settings:

> "There is a significant shortfall in CBT [cognitive behavioural therapy] and specific psychological interventions" (mental health commissioner).

> "Profound lack of provision of psychological therapies for complex mental health needs and psychosis at all levels from inpatient, rehabilitation,

community, early intervention, and assertive outreach" (mental health professional, statutory sector).

Different stakeholders highlighted a range of other specific gaps in provision for different groups of services users. Considerable concern was expressed about deficiencies in services for children and young adults:

> "When a 14-year-old won't open up or talk, there is nothing for them. They are completely abandoned and left to their own devices, even when parents are begging for help and concerned for their teenager's health and wellbeing" (service user).

> "There are gaps in services to support young peoples' transition to adult services – needs to be tailored community support" (mental health professional, voluntary sector).

> "Eating disorders service, talking therapy, and counselling" (service user).

> "Access to psychological therapies for older people - we know that population representative figures are very low for older people with the expected percentage of need being more than twice what we see in referral rates" (mental health professional, statutory sector).

5.3.4 Limitations of Hospital-Based Provision

It was evident from different stakeholder responses that inadequacies in community resources had significant implications for hospital-based services and pressures on both tended to exert a negative impact on mental health provision as a whole. Many mental health professionals felt there was still too much reliance on hospitalisation due to inadequacies in community care:

> "Too much reliance on meds. [medication] and hospitalisation and not enough care in the community, and not enough staff to ensure care in the community works well" (mental health professional, voluntary sector).

Several commissioners conceded that shortages and pressure to provide sufficient hospital beds in their area was directly related to deficits in community care provision.

> "We have still got some way to go in terms of strengthening community services to where they should be – therefore, we struggle with the bed situation" (mental health commissioner).

> "We still have people in beds who really could cope OK in the community if we had the right level of support for them" (mental health commissioner).

As a corollary to this, some mental health professionals expressed concern about problems in obtaining hospital beds when these were needed, and pointed out the negative implications for service users and carers:

> "The threshold is too high for people to get a hospital bed when they need it" (mental health professional, voluntary sector).

> "There's a significant number of people out in the community who do not cope and who are at risk … admission is now seen as a negative thing and it's not for everybody… that respite isn't available anymore" (mental health professional, statutory sector).

Service users, carers, and mental health professionals highlighted a range of problems with hospital inpatient services and the detrimental impact of inadequacies in community support following discharge after periods of admission. Some service users stated that the hospital setting had not been conducive to addressing their needs and there had been little in place to stimulate or aide their recovery:

> "There was little to do … the only occupational therapy consists of colouring in, painting by numbers like a three-year-old" (service user).

Service users also highlighted inadequacies with the information they received about the mental health system, its resources, welfare benefits, and the impact of medication. Some service users mentioned having to trawl through the internet for information or find out factual information through other users or their carers. In particular, the effects of medication on the mind and body could be severe, and yet

service users were often ‘in the dark’. Severe symptoms exacerbated heightened levels of fear and enforced notions of being fundamentally different to so called ‘normal’ others: a process accentuating stigma. One service user remarked:

> “And so at the very start, you know, before I was leaving hospital, I would have actually liked to have known, just with the … maybe it would have had more relevance to me sort of way as regards the injections” (service user).

Many carers voiced concern about the lack of long-term support for service users, particularly following a period of hospitalisation. This is captured succinctly by one respondent who stated:

> “After a period of time people are released and have no backup support. They go back to square one again. Their strengths need to be identified and highlighted at an early stage to help them re-establish a footing in life again” (carer).

5.3.5 Supported Housing Services, Day Care, and Vocational Services

Whilst it was agreed the move away from hospital-based provision was a positive achievement, some mental health commissioners were critical of the quality of community housing available in specific locations where service users had been placed. In particular, it was felt there was still an over-reliance on shared accommodation, which impacted negatively on service users’ quality of life:

> “Whilst shared environments are important for people with mental health issues it is not an ideal environment for recovery. I think there needs to be increased focus on the development of single unit accommodation” (mental health commissioner).

Some mental health professionals and commissioners also expressed mixed views about the value of traditional forms of day care and felt there were still significant gaps in addressing the social and vocational needs of service users.

> "We have a lot of money tied up in it for a very, very small number of people who are completely and utterly institutionalised and dependent upon it … The traditional day care centre is becoming a thing of the past" (mental health commissioner).

> "One size fits all approach … do not stimulate patients or offer therapeutic interventions" (mental health professional, statutory sector).

In contrast, other commissioners felt there was value in maintaining traditional forms of day care and argued this type of provision was still appropriate, for example, in meeting the needs of service users who were less career minded:

> "Some people think day care needs to be very sophisticated … I don't … they are about an individual … being engaged in a service, the carers are getting relief" (mental health commissioner).

Several commissioners commented on the valuable role played by the voluntary sector in providing day care in the community but identified that this was not always accessible:

> "When people are in recovery and need ongoing support, the voluntary sector, in some areas, has been excellent in providing day care support and supporting people in their recovery, but some areas enjoy better access to that than others" (mental health commissioner).

5.3.6 Access to Mental Health Services in Rural Areas

Feedback from all stakeholder groups indicated that inadequacies in mental health provision tended to be most acute in rural areas of Northern Ireland, particularly those areas that previously had less well developed mental health infrastructures:

> "In more rural areas … that infrastructure is not there … A lot of people on [the] road, time out there trying to see clients is a significant challenge – getting people from rural areas into suitable services is clearly a problem too" (mental health commissioner).

Professional staff also highlighted the particular difficulties faced by service users in accessing mental health services in rural areas:

> "It's the rural nature of our geographical catchment area … the public transport system is rubbish … if you are relying on public transport it's very difficult to get to appointments" (mental health professional, statutory sector).

Inadequacies in community support services in rural areas and locations outside major urban concentrations were also acutely felt by carers. One carer described the impact of lack of services and lack of information about the availability of support as follows:

> "My brother has been to see the doctor regarding his condition twice. He has not been told of any support groups. It does not help that the hospital is in 'X' and he lives in another town where there is nothing to help people. I haven't heard of any support groups for families and have no idea where me and my family could turn to" (carer).

5.3.7 Dominance of Medical Model

Alongside the lack of a holistic approach to service provision, carers, service users and mental health professionals highlighted the limitations of a mental health system they felt, in some areas, was still dominated by a medical model approach to providing care. For example, one service user expressed the following view:

> "Doctors are happy to keep writing prescriptions without review of the patient or their needs. I've been on Prozac for three years and my doctor hasn't once challenged if I still need them. There needs to be more use of talking and alternative therapies" (service user).

Together with concerns about over-reliance on medication some service users also expressed unhappiness about not being treated with respect:

> "Medication is too readily handed out" (service user).

> "They need to see us as human beings first ... not a label" (service user).

Mental health professionals in both the statutory and voluntary sector echoed the view that the mental health system in Northern Ireland was limited by still being influenced by a predominantly medical approach to treatment:

> "Still overly based on medical interventions and biomedical model. Intervention tends to be reactionary as opposed to preventative" (mental health professional, statutory sector).

> "People being handed repeat prescription after repeat prescription with no check up to see if the meds. [medications] are doing the right thing" (mental health professional, voluntary sector).

Generally, most commissioners felt that mental health services had become more diverse with the development of community care and the growth in the provision of psychological therapies. However, one commissioner observed that although much progress had been achieved in developing a recovery orientation, the medical model was still the dominant approach in some areas:

> "In some teams it is very much a medical model [that] dominates. Other professional groups who try to work in different perspectives … are sometimes ignored" (mental health commissioner).

The same respondent also commented that there was a need for mental health services to develop beyond a narrow focus on traditional approaches to treatment:

> "For those people who have a high range of social needs - I don't think their needs are met to the same extent … that whole social side of life we forget … we are still very treatment focused" (mental health commissioner).

5.3.8 Stigma

A range of stakeholder groups highlighted the problem of stigma surrounding mental illness in Northern Ireland. Carers voiced frequent concerns about stigma. It was mooted that not only did the family member suffering from mental illness feel the stigma from their diagnostic label, but so too did the carer. Carers expressed a sense of feeling isolated within their social and community milieus, in having to carrying

an enormous weight, and one that remained throughout the life-course despite the aging demographic in carer profiles.

The salience of stigma was captured evocatively by one respondent:

> "It is as if you've got leprosy, you know. Leprosy, like a stigma" (carer).

Another intimated:

> "Because of the stigma of mental health, carers have… well personally I feel I have sort of succumbed to the stigma and you have this feeling that you keep your head down and you don't talk to people because your family members are mentally ill" (carer).

Mental health professionals frequently referred to the continuing prevalence of stigma, including the view that stigma was reinforced by the media:

> "Stigma is still fed a lot by media … our culture and society is based a lot on guilt … the ignorance that's around, it is undoubtedly there" (mental health professional, voluntary sector).

> "Stigma is terrible, even in hospitals, [someone who had self-harmed] told wasting time and resources" (mental health professional, voluntary sector).

Whilst both mental health commissioners and professional staff expressed the view that attitudes towards mental health had changed for the better, it was felt Northern Ireland lagged behind other countries in addressing this problem, and there was still a long way to go in reducing the impact of stigma:

> "I think it is better than what it was but there is still a big stigma attached to it – other forms of disability are more acceptable" (mental health commissioner).

> "We're badly behind other countries … the stigma of mental health affects everything" (mental health professional, voluntary sector).

5.3.9 Impact on Staff Morale and Stress Levels

The findings provided evidence that lack of funding and resources for mental health services had impacted negatively on the morale of professional staff and managers. Feedback from respondents painted a picture of overloaded and often stressed professionals in the statutory sector struggling to cope with larger caseloads and increased demand for mental health services. The following comments are typical of the views expressed by staff:

> "Given the fact you have a captive audience of people who want to work here something is getting lost in translation … people who should be highly skilled, motivated people get a bit ground down by the system" (mental health professional, statutory sector).

> "Community mental health teams are stretched to the limit, too little staff and too many demands" (mental health professional, statutory sector).

Feedback from respondents indicated that such pressures were resulting in low morale and impacting negatively on the health of professional staff:

> "The sickness is so noticeable … social worker with 70 on their caseload" (mental health professional, voluntary sector).

> "Social workers and community psychiatric nurses are on their heads trying to manage their caseloads … awful lot of them are out sick" (mental health professional, statutory sector).

5.3.10 Concerns About Leadership and the Strategic Challenges Facing Mental Health

Notwithstanding the progress that had been achieved since the Bamford Review, a range of stakeholders expressed concern about both the scale of the strategic challenges now facing the further development of mental health services, and what they perceived as a gap in leadership. The view that, post-Bamford, mental health services in Northern Ireland were facing unprecedented challenges was reflected in the following comment:

> "Bamford warmed up the whole system to change … highlighted the need for new investment and created a momentum for change that has been significantly realised. Probably we are moving into the post-Bamford era and there are tremendous challenges for us in that" (mental health commissioner).

A number of respondents expressed the view that there was not the same drive for service improvement post-Bamford and that lack of leadership in mental health extended beyond those responsible for managing and commissioning services:

> "There is a lack of leadership from politicians and funders, and therefore there appears to be no definitive healthcare provision for people experiencing mental ill health. There are too many short-term programmes for an illness that requires lifetime management" (mental health professional, voluntary sector).

In expressing concerns about future funding, different stakeholders suggested that one of most significant strategic challenges facing mental health was lack of parity with physical (acute hospital) health care. Indeed, the comparison between mental and physical ill health was a recurring theme in the feedback obtained from different stakeholder groups:

> "But how can they treat mental health on an equal basis with other disabilities, when you get the cancer unit in the X hospital sitting on the front of the road, and the mental health place somewhere in the darkness" (carer).

> "My daughter thought because she had a mental illness, that she was getting treated different from other people … and I personally do think that once you've got a mental illness you are treated differently from other people" (carer).

Mental health professional staff and commissioners also expressed a perception that mental health services were more vulnerable to financial cuts than the physical health sector. Given that services had historically experienced underinvestment in comparison to other sectors, such as acute hospital care, it was felt further cuts would have a disproportionate impact on the mental health sector.

> "There are enormous issues around the separation of physical health and mental health … advocates for mental health don't seem to do well…it's not given priority" (mental health professional, voluntary sector).

> "On one hand we are seeing money come into mental health by the same token we are taking it out the back door" (mental health commissioner).

There was also a consensus among commissioners that continuing financial restraint could lead to tensions between the statutory and voluntary sectors as a result of increased competition for scarce resources:

> "The challenge within that relationship now is the whole pressure on the financial purse – there is very little left to trim – we are being forced to look at services we contract with and that will have an impact on relationships" (mental health commissioner).

5.4 Northern Ireland Context – Troubles-Related Issues in the Provision of Mental Health Services

Respondents were asked to comment on any issues arising from the Northern Ireland context, including the legacy of the Troubles, which they felt were particularly relevant to mental health services provision. Whilst some respondents had little to say on this theme, those who expressed views felt that the Troubles had made a significant impact on both community and individual mental health.

5.4.1 Impact of the Troubles on Mental Health

A small number of respondents identified some positive features of the Northern Ireland context, which were helpful for promoting good mental health, and that were not enjoyed by other regions in the United Kingdom or further afield:

> "Communities work reasonably well … people have resettled well and our readmission rates are generally good … a sense of community and belonging … it's not like New York or London" (mental health professional, statutory sector).

However, the majority of stakeholders who commented expressed negative views about the Northern Ireland context and specifically the impact and implications of the Troubles on the mental health of the population. For example, one respondent commented as follows:

> "Because to me the Troubles, they are at the heart of an awful lot of it … the Troubles mean that there is so much mental illness here, so much stress and so much depression in so many areas" (carer).

It was acknowledged by another carer that the impact of the Troubles had been variable across Northern Ireland:

> "I don't know how anybody else feels, but many people have a negative perception of North Belfast … a lot of incidents happened there during the Troubles and people are left with a nervous feeling about it" (carer).

A number of respondents observed that the Troubles had affected the resilience of the population of Northern Ireland creating higher levels of dependency and leading to changes in mental health needs:

> "The profile of clients has changed dramatically [more alcohol/drug issues and ASD]" (mental health professional, voluntary sector)

> "I think there is a resistance to rely on self-help … and a big reliance on prescription drugs … that is one of the big legacies of the Troubles" (mental health professional, voluntary sector).

5.4.2 Transgenerational Trauma

Both mental health commissioners and professionals expressed the view that the legacy of the Troubles was transgenerational and long-term in its impact and would continue to have an adverse effect on the population's mental health:

> "I think there is very significant evidence of transgenerational trauma … A lot of folks get their symptoms managed rather than issues dealt with" (mental health commissioner).

> "The trauma and the problems that have been caused … people here are going to take generations to get over it" (mental health professional, voluntary sector).

Many service users referred to personal stories of how the Troubles had affected them or close family members and highlighted a number of issues related to this theme, including the lack of specific services to meet needs; the impact of fear; and the widespread incidence of trauma. One respondent talked of how large numbers within his neighbourhood had to take Valium as a result of the Troubles. Mothers worried about their grown up sons: would they return home after a night out? Sleepless nights were ubiquitous for parents. These issues were reflected in the following statements:

> "There's a whole generation that has been damaged" (service user).

> "People who see Troubles-related trauma, for example, people who are in hospitals, never receive counselling" (service user).

A number of stakeholders felt that not enough was being done to support those who had experienced mental health problems as a result of the Troubles:

> "More should be done to help victims of the troubles. As a sufferer of PTSD it was private treatment that helped me not NHS" (service user).

> "More emphasis has been put on perpetrators rather than victims … at the moment, I feel like a criminal. I don't speak of my experience … there's nothing out there for us" (service user).

Mental health professionals and commissioners agreed that the legacy of the Troubles was continuing to have a significant detrimental impact on the population of Northern Ireland, and that professional services were struggling to address Troubles-related mental health needs. In this context, several commissioners also highlighted the issue of suicide prevention and expressed concern about why, in spite of this being a top priority, suicide rates continued to be high in certain areas:

> "Acknowledge that we are in a post-conflict situation and address the mental health issues that that brings with it ... We are in no way addressing this issue on the scale it requires" (mental health professional, voluntary sector).

> "We have a very robust suicide prevention strategy … but it is not having any immediate impact on the suicide rate … Very few people are already known to mental health" (mental health commissioner).

It was also acknowledged by commissioners that agencies needed to get better at both recognising and addressing needs arising from transgenerational trauma. A number of commissioners identified that statutory mental health services had particular difficulty in addressing the mental health needs of ex-prisoners who had been combatants during the Troubles. Commissioners noted that ex-prisoners were generally reluctant to engage with statutory mental health services:

> "They are definitely a hidden problem within our demographic, they would contend they have very significant mental health problems but … because of confidentiality control … people are therefore inclined not to engage with services" (mental health commissioner).

Whilst acknowledging the continuing adverse effects of the Troubles on the mental health of the population of Northern Ireland, several commissioners also highlighted the impact of the current recession and how it had compounded a legacy of high levels of social deprivation, poverty, and unemployment:

> "One of the things contributing to demand on services is the unemployment and economic factors, that people are struggling with significant debt and all the issues around that … impacting on their mental and psychological wellbeing" (mental health commissioner).

5.5 Priorities for Further Developing Mental Health Services

Respondents were asked to identify areas of provision in mental health requiring further development. Different stakeholder groups made a wide range of recommendations for improvement. In some cases respondents simply referenced as corollaries their responses to earlier questions about limitations and gaps in mental health services. In other cases respondents took the opportunity to further articulate and reinforce what they considered key priorities or development as outlined under the following thematic headings.

5.5.1 Securing Sufficient Funding and Resources

There was a strong consensus among different stakeholder groups that securing adequate funding for mental health and ensuring provision was protected from financial cutbacks was an essential prerequisite for further developing services. The view that mental health had suffered from a legacy of underfunding and should not now have to experience the same level of savings/cuts as other areas of health and social care was summed up by one mental health commissioner as follows:

> "We should be exempt from savings because we are really only now coming up to the level of investment we should have had years ago" (mental health commissioner).

Many service users and mental health professionals also underlined the need for adequate funding to improve services and the importance of mental health provision being needs led rather than service led:

> "Funding. It's easy to see as someone who was using services for people with mental health issues where the speed and care provided could be improved dramatically with a little bit more funding" (service user).

> "Developing services to suit the needs of clients rather to suit budgets … direct more resources to community-based teams and facilities … maintain staff levels and develop their skills and training" (mental health professional, statutory sector).

In this context one mental health commissioner highlighted the negative consequences for services if adequate future funding was not secured:

> "As I look forward in the years to come I see very little opportunities without some really radical stuff … maybe contracting out things and moving things that are more expensively done in the statutory sector … or stopping doing some things completely" (mental health commissioner).

One service user highlighted their concerns about the often precarious and short-term nature of voluntary sector funding and the personal implications for them of having to cope with the uncertainty this engendered:

> "There is too much reliance upon charitable organisations without guarantee of continuing funding. If such support systems fail, where do I go? I feel suicidal thinking about it" (service user).

5.5.2 Leadership

The need to improve leadership of mental health services in Northern Ireland was highlighted as a key priority by a range of stakeholders. Respondents felt it was essential to fill the perceived gap that had emerged post-Bamford in order to provide direction and create renewed momentum for mental health service improvement.

> "I think we went through a 10- to 12-year golden age for mental health services … in terms of investment in terms of profile etc. I think the risk is that is going to dissipate … the Bamford light having dimmed and without the same focus and leadership mission and urgency" (mental health commissioner).

A number of mental health professionals also expressed concern that the momentum for change had diminished post-Bamford and that improved leadership at all levels was a prerequisite for maintaining and further developing mental health services:

> "I feel strongly that there is a clear lack of good leadership and decision making at Stormont level, within the [HSC] Trust I work in, the lack of

guidance and sense of uncertainty is demoralizing" (mental health professional, statutory sector).

The lack of someone who would champion mental health in Northern Ireland and provide the direction, commitment, and drive essential for the ongoing development of services was also highlighted:

> "Still no huge champion of the [mental health] cause within Northern Ireland" (mental health professional, voluntary sector).

5.5.3 Better Integration, Access, and Improved Communication

There was a consensus among stakeholders that better continuity and integration between services, and improving access to provision for service users and carers were key developmental priorities:

> "Continuity is an enormous thing … recovery to home treatment to acute to intensive care … people transferred from one to another … seeing the same person is so important … a bit of continuity makes a big difference" (mental health professional, statutory sector).

> "There are difficulties in accessing services – we try and bring whatever services we have closer to people's homes – but there needs to be more of that" (mental health commissioner).

Many service users also highlighted the need to improve access, address fragmentation between services, and enhance communication with professionals:

> "Ensuring hospital beds are available when needed … better communication with, and respect for patients … having the proper diagnosis and continuation of care" (service user).

The importance of achieving better access and a more joined-up approach to service delivery for promoting service user recovery was echoed by professional staff. For example, one responded highlighted the need for:

> "Linking all services from hospital bed right through to recovery and supporting the client in their individual journey" (mental health professional, voluntary sector).

5.5.4 Early Intervention and Improving Mental Health Education

In addition to integrated services, respondents suggested there needed to be a large scale review of the mental health system aimed at further developing early intervention services and ensuring these were made more accessible. Respondents expressed the view that more timely responses in addressing mental health needs were an essential prerequisite for preventing relapse, alleviating stress, and mitigating risks. Carers, for example, highlighted the need to avoid the additional stress that resulted from poor response times:

> "A more instantaneous response rather than getting an appointment six months down the line. You know, people are ill and they are sitting in the house ill" (carer).

Service users also made the point that increased investment in early intervention and better publicity about what provision was available would help to improve the efficiency and effectiveness of service delivery for both individuals and families affected by mental health problems:

> "Start with the younger generation and problems might not be as bad in the future" (service user).

> "Making the services available more widely known. I wasn't aware of any options available in general until I was at my lowest. If I had known earlier I could have handled a lot of my issues much better" (service user).

Mental health commissioners also highlighted the importance of securing greater investment in preventative strategies for young service users who had experienced psychosis:

> "Early intervention … first episode psychosis … because we know if we can very effectively manage somebody in that first episode then they are less likely to develop a mental health career" (mental health commissioner).

> **"**A lot more needs to be done in terms of getting access to psychological therapy much earlier in someone's illness and certainly as close as possible to a diagnosis or identification of a problem" (mental health commissioner).

Alongside early intervention, all stakeholders identified improving mental health education and mental health promotion as developmental priorities. Connecting with the theme of early intervention, one carer, for example, succinctly highlighted the importance of improving mental health education in schools and colleges:

> "Education of young people in schools and colleges of awareness to mind mental health, in order to avoid long-term engagement with psychiatric services" (carer).

Service users and mental health professionals also expressed the view that the media and employing organisations in Northern Ireland could do more to raise general awareness about the importance of mental health and provide support to employees who had experienced mental health problems:

> "Educate the public via the media etc. on what mental illness is and isn't" (service user).

> "Raising awareness of mental ill health across all organisations. Education of employers to support staff with mental health illness" (mental health professional, voluntary sector).

5.5.5 'Normalising' Mental Illness, Reducing Stigma

There was a general consensus among respondents that mental health provision was still 'out on a limb' with even the spatial location of services within hospitals and health centres in some areas suggesting that mental health was a 'back stage' resource: something to be hidden from 'normal' view. To combat the societal stigma still attached to mental illness, a range of respondents felt it had to be brought into

the foreground along with other types of acute and community services as opposed to being a 'Cinderella' service. Many service users highlighted the need for mental health services to be fully integrated within the mainstream health system for both practical but also symbolic reasons:

> "There needs to be an integrated mental health team along with GPs" (service user).

> "We have to move into general medicine to get rid of stigma" (service user).

A majority of stakeholders ranked the need to address stigma high among the key priorities for improving mental health services: raising awareness and improving understanding of mental illness was considered essential to alleviate the social isolation and discrimination experienced by service users and carers and ensure they received the services they needed. Many mental health professionals, for example, expressed the view that the stigma surrounding mental illness could be alleviated by better health promotion and by treating it in the same way as physical illness:

> "Public health agenda, prevention and getting into schools, positive mental health as a core value … getting rid of stigma" (mental health professional, statutory sector).

> "More awareness campaigns to allow people to talk freely about their mental health and challenge stigma" (mental health professional, voluntary sector).

Furthermore, as part of the process of reducing stigma and normalising mental illness, it was also considered essential for mental health to be accorded the same priority as services provided for physical illness:

> "Mental health services have to be given greater priority than they currently receive. There is still a strong feeling that physical ailments are seen as more important or more worthy of attention" (service user).

5.5.6 Promoting a Recovery Ethos and Further Developing Service User Involvement

Both mental health professionals and commissioners acknowledged that further developmental work was required to ensure a recovery approach was firmly embedded in working practices with service users:

> "Increase recovery model to aid individuals in Northern Ireland with chronic mental ill health" (mental health professional, statutory sector).

A number of respondents connected the promotion of recovery with the need to reduce the prevalence of a medical model approach and improve 'talking therapies' as reflected in the following comments:

> "A bigger push for talking therapies (where appropriate) for treatment compared with a reliance on medication - achieve a better balance to promote recovery" (mental health professional, voluntary sector).

> "Service user appointments focus almost exclusively on medication management … I have never understood why pressure was not applied by government and the health board to encourage medical model psychiatrists to do therapy" (service user)

However, it was acknowledged that there were different perspectives on what constituted a recovery approach:

> "There is a tension between what might be the service user view of what a recovery focused service would be and a lot of professionals' views … you don't change culture overnight" (mental health commissioner).

In this context it was suggested that involving service users more meaningfully in service development and delivery was key to changing mental health practice cultures.

> "Service users are the best placed to actually know what the services should be like and how the small changes could make a real difference, but unless they

are involved in a way that is meaningful, it doesn't work" (mental health professional, voluntary sector).

Commissioners were also unanimous in highlighting the need to further develop service user involvement.

> "You only change culture over time … by changing practice, and that means having more service users actively involved in the delivery of services" (mental health commissioner).

5.5.7 Better Inclusion of Carers

Carers strongly expressed the view that there was a need to involve them to a much greater extent in mental health service provision. For example, carers described their experiences of accompanying their relative to appointments and not being asked their view about progress or having their concerns acknowledged. Carers argued that professionals needed to involve them more in order to understand the important insights they had about their relative, which the relative might be reluctant to convey.

> "The carer is the primary source and they don't seem to go to the primary source. They ask the person who in mentally unwell" (carer).

For carers, inclusion meant having empathy with their daily struggle, the professional putting themselves in the carer's shoes, taking on their perspective, and viewing them as a partner in the helping process. Achieving this would mean tuning-in to particular concerns that worried carers, including threatened cuts to benefits and fear for the future, and who might look after their relative. A number of mental health professionals acknowledged carers' concerns in this context and agreed there was a need for better partnership working for all those involved in service provision:

> "More of a partnership between the user, the carer, and professionals … Co-ordinated approaches that can be seen on the ground" (mental health professional, voluntary sector).

5.5.8 Better Partnership Working Between the Statutory and Voluntary Sectors

Mental health commissioners identified the need to further improve partnership working with the voluntary sector and expressed the view that there was also scope for voluntary organisations to provide a greater range of services. For example, as one respondent commented:

> "There is a very significant role for lots of other organisations … to be providing services at step two and sometimes sub-contracted at step three" (mental health commissioner).

Professional staff from the voluntary sector echoed this perspective and pointed out that greater involvement from the voluntary sector could help to promote community care and reduce over-reliance on statutory services:

> "Less emphasis on being kept in the system of the statutory services and more referrals to services in the community that can help people remain at home, support their recovery and independence and help them to be less reliant on mainstream mental health services"(mental health professional, voluntary sector).

However, many respondents working in the voluntary sector alluded to the lack of cohesion between services and between sectors, as well as gaps and geographical variations in service provision:

> "Geographical gaps; not enough services to support long-term mental health issues in the community; not enough outreach services" (mental health professional, voluntary sector).

> "Gaps in provision between Health Trusts and community and voluntary sector. There needs to be a link between statutory and voluntary sectors" (mental health professional, voluntary sector).

Whilst identifying the scope for improved collaboration between the statutory and voluntary sectors, mental health commissioners felt there was also a need for better collaboration between different voluntary sector providers:

> "There is probably too many of them – I think there is a very significant amount of competition and a dearth of collaboration" (mental health commissioner).

Some commissioners observed that, more recently, collaboration between voluntary sector organisations had significantly improved. However, they argued that further progress was essential given the current climate of financial restraint:

> "There is evidence around now … of voluntary sector providers coming together to provide a service across the region - I think the community/voluntary sector, in order to survive, will have to increasingly think like that" (mental health commissioner).

5.5.9 Need for Less Risk Averse Approaches and Improving Quality Assurance Systems

There was agreement among different stakeholders on the need to move away from what was perceived to be a risk averse and blame culture in mental health provision. In making the case for change, stakeholders expressed the view that a risk averse approach had tended to restrict professional practice and limit service user choice:

> "We can be challenged about being risk averse in terms of how we do things but that is in the context of a system that is risk averse. People are cautious in how they do things because … if something goes wrong, there is more of a blame culture, we see it in the media, we see in the MLAs [Member of Legislative Assembly]" (mental health commissioner).

> "More choice and allowing for reasonable positive risk taking" (mental health professional, voluntary sector).

Mental health commissioners acknowledged that there had been movement on this issue recently and that service users had been instrumental in creating an impetus for change:

> "I think, at the minute, there is an explicit (both within the Department, Board, and Trusts) avowal of being in a position to take more risks safely managed,

> safely understood but risks nonetheless compared with 10 years ago … Reflects a strong view of service users" (mental health commissioner)

Whilst it was felt the introduction of new policy guidance would help to promote change in this area, some respondents were still concerned that service user record and information systems still reflected a degree of paternalism among professionals.

> "The introduction of the *Regional Care Pathway* will drive us in that direction … therefore measuring the process becomes less important than measuring the outcome" (mental health commissioner).

> "There is a certain amount of paternalism around … we should be moving towards people having more access to their notes … the issue in Northern Ireland around confidentiality is that's it's impossible" (mental health professional, statutory sector)

However, a number of commissioners expressed dissatisfaction with existing outcome measures in mental health and felt these needed to be further developed as they did not adequately capture the quality of service delivery in a meaningful way:

> "Targets in mental health are very limited – they are better on the acute side because it is easier to get matrices – one of the challenges for us is finding better outcome measures" (mental health commissioner).

Acknowledging the inadequacy of existing methods of measuring outcomes, mental health professionals suggested possible ways of improving current systems:

> "To have customer surveys done anonymously for all clients yearly, to give feedback to their treating professional" (mental health professional, statutory sector).

6 Conclusion

This report presents comprehensive information about the current state of mental health service provision in Northern Ireland from the perspectives of service users, carers, professionals in the statutory and voluntary sectors, and those involved in commissioning services. The study identifies that mental health services in Northern Ireland have many strengths. Significant progress has been made in moving away from long-stay care in hospitals towards a service that is based primarily on care in the community. In essence, much has been achieved in realising the Bamford Vision for improving mental health provision, including progress in promoting a recovery ethos and developing service user involvement in the planning and delivery of services. The findings indicate that the dedication and commitment of professional staff in both the statutory and voluntary sectors are a very positive feature of mental health services in Northern Ireland. It is also clear that the voluntary and community sectors, working in conjunction with statutory services, make a significant contribution to meeting mental health needs and are often involved in progressing innovative service developments.

However, the study also highlighted a number of significant gaps and limitations, including problems arising from the fragmentation of services that have created difficulty for both service users and carers to access appropriate services to meet their needs. Respondents from all of the groups surveyed expressed serious concerns about the detrimental impact of continuing efficiency savings in mental health and their negative impact on service development. Stakeholders also expressed their fears that not only would much needed developments, such as improvements to therapeutic services, respite care and early intervention services not be realised, but also that the progress already achieved would be lost through further cutbacks. Together with highlighting the need for additional funding to put mental health care on a par with physical health care, respondents identified that a vacuum in leadership had developed post-Bamford, and there had been a loss of focus, drive, and ambition for service improvement. Given the current climate of financial restraint and the scale of strategic challenges facing mental health, it was felt that new leadership would be crucial in sustaining the progress that had already been made in realising the Bamford Vision and achieving much needed, further improvements to services.

Promoting good mental health and wellbeing in Northern Ireland is vital for both individuals and families if our society is to grow and prosper. Given the many competing demands for resources in health and social care, developing mental health services presents complex challenges. This study does not claim to provide a blueprint with all the answers. Nevertheless, the study clearly identifies opportunities for service development that will benefit all involved, and signposts directions for further improvement that policy makers and agencies may find helpful in enabling them to plan and deliver effective services in future.

References

Bamford Review of Mental Health and Learning Disability (2005) *A Strategic Framework for Adult Mental Health Services*, Belfast: DHSSPS. Available at: http://www.dhsspsni.gov.uk/index/bamford/published-reports.htm

Bamford Review of Mental Health and Learning Disability (2006a) *Human Rights and Equality Report*, Belfast: DHSSPS. Available at: http://www.dhsspsni.gov.uk/index/bamford/published-reports.htm

Bamford Review of Mental Health and Learning Disability (2006b) *Forensic Services Report*, Belfast: DHSSPS. Available at: http://www.dhsspsni.gov.uk/index/bamford/published-reports.htm

Bamford Review of Mental Health and Learning Disability (2006c) *A Vision of a Comprehensive Child and Adolescent Mental Health Service (CAMH)*, Belfast: DHSSPS. Available at: http://www.dhsspsni.gov.uk/index/bamford/published-reports.htm

Bamford Review of Mental Health and Learning Disability (2006d) *Autistic Spectrum Disorders (ASD) Report*, Belfast: DHSSPS. Available at: http://www.dhsspsni.gov.uk/index/bamford/published-reports.htm

Bamford Review of Mental Health and Learning Disability (2007a) *A Comprehensive Legal Framework for Mental Health and Learning Disability*, Belfast: DHSSPS. Available at: http://www.dhsspsni.gov.uk/index/bamford/published-reports.htm

Bamford Review of Mental Health and Learning Disability (2007b) *Living fuller lives: dementia and mental health issues in older age*, Belfast: DHSSPS. Available at: http://www.dhsspsni.gov.uk/index/bamford/published-reports.htm

Bolton, J. (2012) 'We've got another one for you!': Liaison psychiatry's experience of stigma towards patients with mental illness and mental health professionals', *The Psychiatrist*, 36 (12), pp. 450-454.

Bunting, B.P., Ferry, F.R., Murphy, S.D., O'Neill, S.M. and Bolton D. (2013) 'Trauma associated with civil conflict and posttraumatic stress disorder: Evidence from the Northern Ireland study of health and stress', *Journal of Traumatic Stress,* 26(1), pp. 134-141.

Bunting, B.P., Murphy, S.D., O'Neill, S.M. and Ferry, F.R. (2012) 'Lifetime prevalence of mental health disorders and delay in treatment following initial onset: Evidence from the Northern Ireland Study of Health and Stress', *Psychological Medicine*, 42(8), pp. 1727-1739.

Bunting, B., Murphy, S., O'Neill, S. and Ferry, F. (2013) 'Prevalence and treatment of 12-month DSM-IV disorders in the Northern Ireland study of health and stress', *Social Psychiatry and Psychiatric Epidemiology*,48(1), pp. 81-93.

Cameron, D., Maxwell, H. and Kapur, R. (2007) 'A bridge too far: The living learning experience of life and death in a residential community for personality disorder in Northern Ireland', *Therapeutic Communities,* 28 (2), pp. 148-161.

Campbell, A., Cairns, E. and Mallett, J. (2004) 'Northern Ireland: The psychological impact of "the troubles"', *Journal of Aggression, Maltreatment and Trauma,* 9(1-2), pp. 175-184.

Care Services Improvement Partnership/National Institute for Mental Health in England, Changing Workforce Programme & Royal College of Psychiatrists (2005) *New Ways of Working for Psychiatrists: Enhancing Effective, Person-Centred Services through New Ways of Working in Multidisciplinary and Multi-Agency Contexts. Final Report 'But Not the End of the Story'*. London: Department of Health.

Centre for Economic Performance (2012) *How Mental Illness Loses Out in the NHS*, London: London School of Economics and Political Science.

Commission for Victims and Survivors (2005) *Towards a Better Future: The Trans-generational Impact of the Troubles on Mental Health,* Belfast. Commission for Victims and Survivors.

Cousins, W., Taggart, L., Milner, S., Cousins, W., Taggart, L. and Milner, S. (2010) 'Looked after or overlooked? An exploratory investigation of the mental health issues of adolescents living in state care in Northern Ireland', *Psychology Health & Medicine*, 15(5), pp. 497-506.

Couture, S. and Penn, D.L. (2003) 'Interpersonal contact and the stigma of mental illness: A review of the literature', *Journal of Mental Health*, 12(3), pp. 291–305.

Cutcliffe, J.R., McKenna, H., Keeney, S., Stevenson, C. and Jordan, J. (2013) 'Straight from the horse's mouth': Rethinking and reconfiguring services in Northern Ireland in response to suicidal young men', *Journal of Psychiatric & Mental Health Nursing*, 20(5), pp. 466-472.

Davidson, G. and Campbell, J. (2007) 'An examination of the use of coercion by assertive outreach and community mental health teams in Northern Ireland', *British Journal of Social Work*, 37(3), pp. 537-555.

Davidson, G., Duffy, J., Barry, L., Curry, P., Darragh, E., Lees, J. and Davidson, A.F. (2012) 'Championing the interface between mental health and child protection: Evaluation of a service initiative to improve joint working in Northern Ireland', *Child Abuse Review*, 21(3), pp. 157-172.

Davidson, G. and Leavey, G. (2010) 'Promoting mental health in Northern Ireland: Addressing division, inequality and stigma', *Journal of Public Mental Health*, 9(4), 6-15.

Department of Health (2010) *Equity and Excellence: Liberating the NHS*, Norwich: The Stationary Office.

Department of Health, Social Services and Public Safety (2009) *Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Action Plan 2009-2011*, Belfast: Department of Health, Social Services and Public Safety. Available at: http://www.dhsspsni.gov.uk/bamford_action_plan_2009-2011.pdf

Department of Health, Social Services, and Public Safety (2010) *Reshaping the System: Implications for Northern Ireland's Health and Social Care Services of the 2010 Spending Review* ('McKinsey Report'), Belfast: Department of Health, Social Services, and Public Safety. Available at: http://www.dhsspsni.gov.uk/index/mckinseyreport.htm

Department of Health, Social Services, and Public Safety (2011) *Transforming Your Care: A Review of Health and Social Care in Northern Ireland,* Belfast: Department of Health, Social Services, and Public Safety. Available at: http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf

Department of Health, Social Services, and Public Safety (2012a) *Evaluation of the Bamford Review Action Plan 2009-2011,* Belfast: Department of Health, Social Services, and Public Safety. Available at: http://www.dhsspsni.gov.uk/bamford-evaluation-action-plan2009-2011.pdf

Department of Health, Social Services, and Public Safety (2012b) *Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Action Plan 2011- 2015,* Belfast: Department of Health, Social Services, and Public Safety. Available at: http://www.dhsspsni.gov.uk/2012-2015-bamford-action-plan.pdf

Department of Health, Social Services, and Public Safety (2013) *Bamford Action Plan 2012-15: Monitoring Report–November 2013,* Belfast: Department of Health, Social Services, and Public Safety. Available at: http://www.dhsspsni.gov.uk/bamford-monitoring-report-november-2013.pdf

Department of Health, Social Services, and Public Safety (2014a) *Bamford Action Plan 2012-15: Monitoring Report–November 2014,* Belfast: Department of Health, Social Services, and Public Safety. Available at: http://www.dhsspsni.gov.uk/bamford-monitoring-report-november-2014.pdf

Department of Health, Social Services, and Public Safety (2014b) *Department of Health, Social Services and Public Safety: Draft Budget 2015/16 Consultation,* Belfast: Department of Health, Social Services, and Public Safety.

Devlin, C., Burnside, L. and Akroyd, L. (2006) 'Mental health vocational rehabilitation: An overview of occupational therapy service provision in Northern Ireland', *British Journal of Occupational Therapy*, 69(7), pp. 334-358.

Donnelly, M., Hughes, J. and Stewart, K. (2007) 'Care management in mental health services in England and Northern Ireland: Do integrated organizations promote integrated practice?' *Journal of Health Services & Research Policy,* 12(4), pp. 236-241.

El Ansari, W., Stock, C., Snelgrove, S., Hu, X., Parke, S., Davies, S., John J., Adetunji, H., Stoate, M., Deeny, P., Phillips, C. and Mabhala, A. (2011) 'Feeling healthy? A survey of physical and psychological wellbeing of students from seven universities in the UK', *International Journal of Environmental Research and Public Health*, 8(5), pp. 1308-1323.

Evans-Lacko, S., Knapp, M., Thornicroft, G. and Mojtabai, R. (2013) 'The mental health consequences of the recession: Economic hardship and employment of people with mental health problems in 27 European countries, *PLoS One*, 8(7): e69792. DOI: 10.1371/journal.pone.0069792.

Faulkner, A. (2009) *Service User and Carer Involvement in the National Mental Health Development Unit: Scoping Report*, London: National Survivor User Network.

Friedli, L. and Parsonage, M. (2007) *Mental Health Promotion: Building an Economic Case*, Belfast: Northern Ireland Association for Mental Health.

Gallagher, E., Hamber, B. and Joy, E. (2012) 'Perspectives and possibilities: Mental health in post-agreement Northern Ireland', *Shared Space: A Research Journal on Peace, Conflict and Community Relations in Northern Ireland*, 13 (March), pp. 63-78.

Gilburt, H., Edwards, N. and Murray, R. (2014) *Transforming Mental Health: A Plan of Action for London,* London: The King's Fund.

Graham L., Parke R.C., Paterson M.C. and Stevenson M. (2006) 'A study of the physical rehabilitation and psychological state of patients who sustained limb loss as

a result of terrorist activity in Northern Ireland 1969-2003', *Disability and Rehabilitation,* 28(12), pp. 797-801.

Ham, C., Heenan, D., Longley, M., and Steel, D.R. (2013) *Integrated care in Northern Ireland, Scotland and Wales: Lessons for England*, London: The King's Fund.

Health and Social Care Board (HSCB) (2013) *Transforming Your Care: Strategic Implementation Plan*, Belfast: Health and Social Care Board. Available at: http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf

Houdmont, J., Kerr, R. and Addley, K. (2012) 'Psychosocial factors and economic recession: The Stormont study', *Occupational Medicine,* 62(2), pp. 98-104.

Houses of Parliament Parliamentary Office of Science and Technology (2015) *Parity of Esteem for Mental Health* (*Postnote. Number 485),* London: The Parliamentary Office of Science and Technology.

Jordan, J., McKenna, H., Keeney, S., Cutcliffe, J., Stevenson, C., Slater, P. and McGowan, I. (2012) 'Providing meaningful care: Learning from the experiences of suicidal young men', *Qualitative Health Research*, 22(9), pp. 1207-1219.

Kalathil, J. (2013) *Dancing to our own tunes: Reassessing black and minority ethnic mental health service user involvement,* London: CC Media Group.

Kelly, C.M., Jorm, A.F. and Wright, A. (2007) 'Improving mental health literacy as a strategy to facilitate early intervention for mental disorders', *Medical Journal of Australia,* 187(7), pp. 27-30.

Knapp, M., McDaid, D. and Parsonage, M. (editors) (2011) *Mental Health Promotion and Mental Illness Prevention: The Economic Case*, London: Department of Health.

Knapp, M., McDaid, D., Thornicroft, G. and Mossialos, E. (2006) 'Mental Health Policy and Practice across Europe: An overview' in Knapp, M.,McDaid, D.,

Mossialos, E. and Thornicroft, G. (editors.), *Mental Health Policy and Practice across Europe*, New York: Open University Press, pp. 1-14.

Lee, S., Lee, M.T., Chiu M.Y., and Kleinman, A. (2005) 'Experience of social stigma by people with schizophrenia in Hong Kong', *The British Journal of Psychiatry*, 186(2), pp. 153-157.

Lewis, C.A., Shevlin, M., Francis, L.J. and Quigley, C.F. (2011) 'The association between church attendance and psychological health in Northern Ireland: A national representative survey among adults allowing for sex differences and denominational difference', *Journal of Religion & Health*, 50(4), pp. 986-95.

Lloyd, K. and Devine, P. (2012) 'Psychometric properties of the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) in Northern Ireland', *Journal of Mental Health*, 21(3), pp. 257-263.

Lock, H. (2015) *'Mental health research: Underfunded and failing to attract young academics', The Guardian,* 18 February 2015.

Mahedy, L., Todaro-Luck, F., Bunting, B., Murphy, S. and Kirby, K. (2013) 'Risk factors for psychological distress in Northern Ireland', *International Journal of Social Psychiatry*, 59(7), pp. 646-654.

McClean, R.J. (2010) 'Assessing the security needs of patients in medium secure psychiatric care in Northern Ireland', *Psychiatrist*, 34(10), pp. 432-436.

McConnell, D., O'Neill, S., Murphy, S.D., Shorter, G.W. and Ferry, F. (2012) 'Help seeking behaviour for mental health problems: Analysis of the Northern Ireland Study of Health and Stress'. Paper presented at the *European Health Psychology Society Conference*, Prague, Czech Republic, 21st – 25th August, 2012.

McDaid, D., Curran, C. and Knapp, M. (2005) 'Promoting mental well-being in the workplace: A European policy perspective', *International Review of Psychiatry*, 17(5), pp.365–373.

McFeeters, D., O'Neill, S.M., Murphy, S.D., Shorter, G.W. and Ferry, F. (2012) 'Employment correlates of mental health in Northern Ireland'. Paper presented at the

European Health Psychology Society Conference, Prague, Czech Republic, 21st – 25th August, 2012.

McGilloway S. and Donnelly, M. (2004) 'Mental illness in the UK criminal justice system: A police liaison scheme for mentally disordered offenders in Belfast', *Journal of Mental Health*, 13(3), pp. 263-275.

McKenna, A.E., Cassidy T. and Giles, M. (2014) 'Prospective evaluation of the pyramid plus psychosocial intervention for shy withdrawn children: An assessment of efficacy in 7- to 8-year-old school children in Northern Ireland', *Child and Adolescent Mental Health,* 19(1), pp. 9-15.

McMillan, F.V., Browne, N., Green, S. and Donnelly D. (2009) 'A card before you leave: participation and mental health in Northern Ireland', *Health & Human Rights,* 11(1), pp. 61-72.

McNamee, H., Lloyd, K. and Schubotz, D. (2008) 'Same sex attraction, homophobic bullying and mental health of young people in Northern Ireland', *Journal of Youth Studies,* 11(1), pp. 33-46.

McNeill, O. and Ingram, R. (2009) 'Current psychotherapy training for psychiatry trainees in Northern Ireland', *Irish Journal of Psychological Medicine,* 26(4), pp. 194-196.

Mental Health Foundation (2013) *Starting Today: The Future of Mental Health Services,* London: King's College London.

Merzel, C. and D'Afflitti, J. (2003) 'Reconsidering community-based health promotion: Promise, performance, and potential'. *American Journal of Public Health*, 93(4), pp. 557–574.

Muldoon, O.T. and Downes, C. (2007) 'Social identification and post-traumatic stress symptoms in post-conflict Northern Ireland', *British Journal of Psychiatry,* 191(2), pp. 146-149.

Murphy, H. (2008) 'The troubles', geographies of mental health in Northern Ireland and re-conceptualizing social capital', *Critical Public Health,* 18(1), pp. 51-64.

Murphy, H. and Lloyd, K. (2007) 'Civil conflict in Northern Ireland and the prevalence of psychiatric disturbance across the United Kingdom: A population study using the British household panel survey and the Northern Ireland household panel survey', *International Journal of Social Psychiatry*, 53(5), pp. 397-407.

Myers, E., Hewstone, M. and Cairns, E. (2009) 'Impact of conflict on mental health in Northern Ireland: The mediating role of intergroup forgiveness and collective guilt', *Political Psychology*, 30(2), pp. 269–290.

Northern Ireland Association for Mental Health (2004) *Counting the Cost: The Economic and Social Cost of Mental Illness in Northern Ireland,* Belfast: Sainsbury Centre for Mental Health.

Northern Ireland Executive (2012b) *Programme for Government 2011-2015,* Belfast: Northern Ireland Executive. Available at: http://www.northernireland.gov.uk/pfg

Northern Ireland Executive (2015) *Budget 2015-16,* Belfast: Northern Ireland Executive. Available at: http://www.northernireland.gov.uk/budget-2015-16.pdf

O'Connor, R.C., Rasmussen, S. and Hawton, K. (2014) 'Adolescent self-harm: A school-based study in Northern Ireland', *Journal of Affective Disorders,* 159, pp. 46-52.

Office of the First Minister and Deputy First Minister (2012) *Summary of Findings from Written Responses to the Consultation on the Draft Programme for Government 2011-15,* Belfast: Office of the First Minister and Deputy First Minister. Available at: http://www.northernireland.gov.uk/pfg

O'Neill, S., Corry, C.V., Murphy, S., Brady, S. and Bunting, B.P. (2014) 'Characteristics of deaths by suicide in Northern Ireland from 2005 to 2011 and use of health services prior to death', *Journal of Affective Disorders,* 168, pp. 466-471.

O'Neill, S., Ferry, F., Murphy, S., Corry, C., Bolton, D., Devine, B., Ennis E. and Bunting, B. (2014) 'Patterns of suicidal ideation and behaviour in Northern Ireland and associations with conflict related trauma', *PLoS ONE,* 9(3): e91532. DOI: 10.1371/journal.pone.00915329.

Organisation for Economic Cooperation and Development (2014) *Focus on Health: Making Mental Health Count*, Paris: Organisation for Economic Cooperation and Development.

Pidgeon, C. (2011) *Mental Health Expenditure. Research and Information Service Briefing Note*, Paper 102/11. NIAR 547-11. Belfast: Northern Ireland Assembly.

Pinfold, V., Toulmin, H., Thornicroft, G., Huxley, P., Farmer, P. and Graham, T. (2003) 'Reducing psychiatric stigma and discrimination: Evaluation of educational interventions in UK secondary schools', *British Journal of Psychiatry*, 182(4), pp. 342-346.

Pinto-Meza, A., Moneta, M.V., Alonso, J., Angermeyer, M.C., Bruffaerts, R., Caldas de Almeida, J.M., de Girolamo, G., de Graaf, R.,Florescu, S., Kovess Masfety, V., O'Neill, S., Vassilev, S. and Haro, J.M. (2013) 'Social inequalities in mental health: Results from the EU contribution to the World Mental Health Surveys Initiative', *Social Psychiatry and Psychiatric Epidemiology*, 48(2), pp. 173-81.

Plamping, D., Gordon, P. and Pratt, J. (2000) 'Practical partnerships for health and local authorities', *British Medical Journal*, 320 (7251), pp. 1723–1735.

Prior, P. (1993) *Mental Health and Politics in Northern Ireland: A History of Service Development*, Aldershot: Avebury.

QUB Budget Analysis Project (2013) *Human Rights Obligations and Budgeting for Mental Health in Northern Ireland*, Belfast: Queen's University Belfast. Available at: http://www.qub.ac.uk/schools/SchoolofLaw/Research/HumanRightsCentre/ResearchProjects/BudgetAnalysis/Documents/

Reilly, S., Challis, D., Burns, A. and Hughes, J. (2004) 'The use of assessment scales in old age psychiatry services in England and Northern Ireland', *Aging & Mental Health*, 8(3), pp. 249-255.

Rice, F., Cullen, P., Mckenna, H., Kelly, B., Keeney, S. and Richey, R. (2007)'Clinical supervision for mental health nurses in Northern Ireland: formulating

best practice guidelines', *Journal of Psychiatric and Mental Health Nursing,* 14(5), pp. 516-521.

Roberts, G. and Hollins, S. (2007) 'Recovery: our common purpose?' *Advances in Psychiatric Treatment,* 13(6), pp. 397–399.

Sainsbury Centre for Mental Health (2007) *Mental health at work: Developing the business case* (policy paper 8) [online] London: Sainsbury Centre for Mental Health. Available at: http://www.incorporasaludmental.org/images/doc/D_ENG_EMP_DOCU_GUIA_0036_Developing_the_business_case.pdf

Schubotz, D. and O'Hara, M. (2011) 'A shared future? Exclusion, stigmatization, and mental health of same-sex-attracted young people in Northern Ireland*', Youth and Society,* 43(2), pp. 488-508.

Shepherd, G., Boardman, J. and Burns, M. (2010) *Implementing Recovery. A methodology for organisational change*. London: Sainsbury Centre for Mental Health.

Shepherd, G., Boardman, J. and Slade, M. (2008) *Making Recovery a Reality*, London: Sainsbury Centre for Mental Health.

South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust (2010) *Recovery is for All: Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists*. London: South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust

Survey Monkey Inc. (1999-2015) *SurveyMonkey*, SurveyMonkey Inc.: Palo Alto, California, USA. Available at: https://www.surveymonkey.com

Tait, L. and Lester, H. (2005) 'Encouraging user involvement in mental health services', *Advances in Psychiatric Treatment* 11, pp. 168–175.

Taylor, L.K., Merrilees, C.E., Cairns, E., Shirlow, P., Goeke-Morey, M. and Cummings, E.M. (2013) 'Risk and resilience: the moderating role of social coping

for maternal mental health in a setting of political conflict', *International Journal of Psychology,* 48(4), pp. 591-603.

Valmaggia, L.R., McCrone, P. and Knapp, M. (2009) 'Economic impact of early intervention in people at high risk of psychosis', *Psychological Medicine,* 39(10), pp. 1617–1626.

Wilson, G. and Daly, M.(2007) 'Shaping the future of mental health policy and legislation in Northern Ireland: The impact of service user and professional social work discourses', *British Journal of Social Work,* 37(3), pp. 423-439.

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